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Original Articles.

CASES FROM PRACTICE.

By H. V. Sweringen, M.D., Fort Wayne, Indiana.

A BIT OF OBSTETRICAL EXPERIENCE.

About 7 o'clock p.m., Wednesday, March 14, 1883, the writer hereof was called to attend the first confinement of Mrs. M., æt. 26, residing at No. 40 South Clay street, Fort Wayne, Indiana. While accompanying the messenger, the husband, to his residence, we met Mr. McB., who, on a like mission, was making his way in great haste to my house, and whose wife, he felt assured, would, as was usual with her, have a speedy delivery.

Inasmuch as Mr. McB's. residence is but a few squares distant from that of Mr. M., and his wife a multipara, the other case being a primipara, I concluded that I could attend to both: the vision of a double obstetric fee probably having some influence in prompting the decision. In accordance with which conclusion, however, I informed the second messenger that I would first see Mrs. M. and then go immediately to his house, where I thought I could remain until Mrs. McB.'s labor terminated before returning to the house of No. 1.

We arrived in the course of a few minutes at the house of case first and learned that she had experience more or less pain and unweariness during the entire day until 4 p.m., when more active labor set in, although she decided to wait until her husband returned from his work before sending for her physician.

Upon making an examination we discovered that considerable progress had already been made, the os dilated to the size of a silver dollar, the presentation natural, the caput succedaneum forming and the membranes ruptured.

It was now getting to be a serious question in my mind whether or not

I would be able to deliver both cases. I had on two previous occasions been placed in a like situation and succeeded, but in the present instance began to doubt my ability to perform the feat.

After the lapse of a few minutes I visited case No. 2, made an examination and found that no dilatation whatever had occurred of the os. I then informed her that case No. 1 was likely to come out ahead and leave me plenty of time to attend to her subsequently.

Returning to case No. 1 was informed that during my absence she had some very hard pains and vomited frequently. Congratulating myself upon the prospect of a speedy termination of this case, I again examined to learn only that while the os had almost fully dilated, the descent of the head was barely more marked than in the previous examination. And so we waited and waited, pain after pain of the most sthenic type occurring at regular intervals but not the slightest advancement made. The calls of the husband of case No. 2 now became as regular and frequent as her pains, until I told him he had better go for the nearest physician, it being impossible for me to leave case No. 1, who was, with her attendants, very much discouraged, it being at this time about midnight.

What is there more absolutely provoking to the physician than to witness a patient of this character strain and groan and grunt and scream and defecate and micturate and flatúlate and vomit and moan and lament and strain again, without accomplishing any advancement? "Thou art so near and yet so (condemned) far," are words which have frequently occurred to me under these most exasperating circumstances, and we have not unfrequently been tempted to question the character for mercy and goodness of the Creator in instituting so serious a method for the birth of His creatures. The clock struck one: we were still "waiting for nature." The clock struck two, when it was evident that all concerned had ceased to regard patience as a virtue, and yet the mere suggestion of instrumental interference seemed to chill the friends with fear.

We now sent the husband for our forceps, still indulging a faint hope that ere his return the agony will be a thing of the past. But that glimmer of hope was groundless and merged into an unalterable opinion that Nature would never be equal to the task imposed.

Upon the return of the husband we applied the forceps, and, after no small amount of traction, delivered the now exhausted patient of a living boy, weighing over twelve pounds. Considerable hemorrhage followed the delivery and a slight perineal rupture was discovered. The placenta was firmly attached to the fundus, necessitating the introduction of the hand to effect its detachment, which was even then not easily but completely accomplished. We had just delivered the placenta when the husband of case No. 2 arrived and announced that "the trouble was all over at his house," showing that the "double fee" is not always attainable, although it might have been in this instance if the friends of case No. 1

would have been satisfied with a short absence of the physician at the proper time.

Now, the subsequent history of case No. 1 is not devoid of interest. On the evening of the 15th her temperature and pulse each registered one hundred, which revelation I regarded as the result of prolonged labor with, perhaps, some slight traumatic or surgical irritation. I prescribed grain doses of opium with five of quinine every four hours and ordered the vagina irrigated with carbolized warm water night and morning, paying no attention to the perineal rent other than directing a lateral decubitus.

On the 16th, 17th and 18th her pulse and temperature continued to mark 100. During this period there existed also, slight paralysis of the vesical sphincter, her urine constantly flowing from her. The lochial discharge had now ceased. On the 19, morning temperature, 102°; evening, 103°; pulse, 100. She was now able to control her bladder. On the 20th, temperature 103° during the entire day. In the absence of any evidence existing of puerperal fever *per se*, and no prominent symptom of septicæmia or pyæmia appearing, I began to consider the case as one of malarial puerperal fever without the history of a perceptible chill. This view was strengtheed by the fact of which, upon inquiry, I was now reminded, that several weeks prior to her accouchment I had prescribed for without seeing her, for what at the time I supposed to be a malarial attack. I therefore decided to give her during the next twenty-four hours, stxty grains of quinine. On the following morning, the 21st, her temperature had fallen to 100° but before noon had risen to 104½°, at which it remained until near midnight, when after sponging the body with warm water and vinegar, it declined one degree; her pulse was now accelerated twelve beats; slight restlessness supervened, but upon one occasion only was there noticed any delirium, and that was mild and transient. I was now giving her ten grains of quinine night and morning, administering in the meantime at frequent though regular intervals, liberal quantities of milk, beef tea and sherry wine. Vomiting was now an occasional symptom.

On the morning of the 22d, temperature, 104°; pulse, 110. At noon the same condition obtained. Visiting her again a few hours later, I resolved to wash out the uterine cavity. Introducing into the cervix a No. 12 flexible catheter in which I had made several holes, I fitted to its exposed extremity the rectal tube of a Davidson syringe through which I injected about three pints of very warm water medicated with a fluid dram of full strength carbolic acid and three and a half each of glycerine and laudanum. The os was open and unobstructed and the returning fluid contained no appreciable detritus, nor was there present any unusual odor. Uterine involution was, of course, not yet complete, perhaps temporarily arrested, and I purposely withdrew the catheter as soon as the fluid was injected in order that as much of it as possible might remain to excite

more or less contraction. After the lapse of about six hours I again visited her, but noted no perceptible change. On the following morning, however, the nurse, meeting me at the door, informed me that during the night Mrs. M. had real after pains and commenced to flow quite freely, discharging several little pieces which looked like dirty tissue paper. Regarding this announcement as favorable I expected what I soon found to be a reality, my patient decidedly better, with a pulse of 96, a temperature of 99°and an herpetic eruption making its appearance about her lips. I have now given a faithful history, or most important facts of the case; the reader may draw his own inferences or make the application.

A CASE OF CEREBRO-SPINAL MENINGITIS.

On Saturday morning, March 24th, 1883, I was called in great haste to see a child four years of age, son of James Tyler, Esq., residing at 287 W. Washington street, Fort Wayne, Indiana. Upon my arrival I discovered the child in a spasm, and remembering that I had treated him on a former occasion for a convulsion due, as I considered, to malaria, I immediately ordered a tub to be brought in half-filled with warm water, to which was to be added about a tablespoonful of mustard. By the time the bath was ready, I expressed the opinion that it could be of no service whatever and had it removed without using it. Having been impressed with the peculiarity of the fit, I concluded it was one of those convulsions which usher in the disease known as cerebro-spinal fever.

There was no history of any premonitory illness whetever. The child had been at play as usual, and when seized with the attack was accidentally or incidentally noticed by the mother to be staring at a crack in the cupboard and perfectly motionless. The mother, resting her arms on the rim of the pan in which she was washing her breakfast dishes, watched the child a moment and then, becoming alarmed, rushed to him to find him entirely unconscious and about to fall. She then laid him on a lounge and sent for her physician.

Probably thirty minutes had elapsed from the time of seizure before any marked convulsive movements were noticed, the child remaining comparatively quiet, "staring with large eyes" as it was said, and perfectly unconscious.

Noticing an unusual degree of stiffness, rigidity and contraction of the muscles of the neck as of those also of the extremities, more particularly marked on the whole of the left side, the pupils dilated to their fullest extent, the head drawn back, the knees drawn up, the left foot reminding me of a club-foot, the forearms flexed upon the arms, the face red, purple, highly congested, the mouth frothing, eyes open with an occasional clonic winking, more especially of the right, in a word, noticing almost such a convulsion as I have observed in tetanus. I at once felt certain that I had to deal with a case of so-called spotted fever.

I have had some experience in the treatment of this disease, but had never observed a case of it ushered in with a convulsion. In those cases in the treatment of which I had been successful, *I blistered early and relied on opium.* I therefore sent for two drachms, of cantharidal collodion and a brush and applied it from ear to ear, all over the nape of the neck and down the spine, nearly to the sacrum. I had with me some third of a grain powders of morphia and a hypodermic syringe. Dissolving in a little water about an eighth or a sixth part of a powder, I injected it into the left arm: never having done the like before to a child of this age. In about an hour I applied the balance of the blistering liquid, and noticed while so doing that that the spinal muscles responded slightly to the brushing. In a short time the blister began to raise, the pupils became a little smaller, though yet irresponsive, the muscular system gradually relaxed, the face grew paler and assumed to a very slight degree the expression of pain, and his general condition was evidently improving. He continued in about this state until 7 p.m., when partial consciousness returned and he spoke one word. Being now able to swallow, I prescribed bromide of potassium and fluid extract of ergot with an occasional dose of laudanum. During the night he seemed to have considerable irritability of the bladder and passed some bloody urine, the result no doubt of absorption of more or less of the blistering liquid. Not five minutes during the night or since the seizure, did he close his eyes; I therefore increased the doses of bromide and laudanum, and the little patient slept better during the second night. Consciousness did not fully return until Monday, when he wanted to know what made his back and neck sore; his countenance still presenting a bewildered picture with slight corrugation of the superciliary muscle, and his words being uttered with difficult articulation. I now believe he is convalescing from a very dangerous attack of cerebro-spinal fever, which was fortunately nipped in the bud, or, in medical parlance aborted. It is my most sacred belief that the child would have died before the expiration of twelve hours had it not been for the treatment instituted.

This opinion is supported by the fact that a boy of the same age in the same neighborhood, attacked the same way, died of what the attending physician pronounced to be the disease in question.

LARGE FAMILIES.—We recently referred to the figures which indicate the slow "depopulation" of France, by excess of deaths over births. M. Pieyre has submitted a Bill for the encouragement of large families. It proposes a recuction of 15 per cent. on the taxes of a father with five children, and a further 5 per cent. for each additional child. Persons not paying direct taxes, or whose taxes do not exceed 100 francs, are likewise to be tempted by a bonus of 200 francs for a fifth child, 300 francs for a sixth, and so on. For this Bill is predicted what the French call a *succès de rire.*

A CASE OF MULTIPLE PREGNANCY.

As Reported to the Butler County Medical Society by CHAS. C. HOOVER, M.D., Ross, O.

Was called on the evening of April 24, 1881, to see Mrs. ——, who had been suffering with slight labor pains during the day. She had menstruated regularly until six and three-fourths months previous to my call. General health not good. Nutrition poor. On making digital examination found the labor already well progressed into the second stage. The os widely dilated and the breach of a small fœtus presenting. The umbilical cord was prolapsed, and despite all efforts to place it above the presenting parts, remained so until the fœtus had been expelled, which occurred in a very short time.

The pulsations of the cord were 144 per minute, and in conformity to the teachings of some eminent authorities, the sex proved to be female.

Throwing two ligatures around the cord and cutting through them, as is my custom, we laid the little stranger aside.

An examination revealed the existence of a second child inclosed in a separate chorion. No. 2 was laying in a transverse position well up in in the fundus. Cephalic version by external manipulation was performed, and a few expulsive pains sufficed for its birth. It, like the first, was alive and a girl. Proceeding as before in the management of the cord, I was soon ready to re-examine what was now becoming an interesting case, and found, to my great surprise, that there was still another to follow. No. 3 was born breech presenting.

Here was a triplet, two girls and a boy, well made and symmetrical, but poorly nourished and premature.

At this juncture the father was called from an adjoining room to behold the new accessions to his family, his look was ludicrous in the extreme—he fairly jumped with amazement.

My examination of the placenta was quite unsatisfactory. There were three separate placentas and three separate chorions. The placentas had marginal attachments, though, probably, no venous communications existed.

The mother made a good recovery, but two of the children died in a few hours, while the third survived them about a week. All efforts made at stimulation were unvailing.

Statistics show the births of triplets to be very rare, occurring but once in 5846 cases.

IN the ruins of Pompeii has been lately discovered a quadrivalve speculum, exquisitely proportioned, with a movement unsurpassed by the most perfected of modern instruments.

Reports of Societies.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF CINCINNATI.

Stated Meeting, March 9th, 1883.

The President, Dr. J. Trush, in the chair.

Dr. Haight read the following paper on

Placenta Previa Complicated with Septicemia.

The case which I desire to report is one of placenta previa, in which Pyemia, due to the absorption of putrid matter from a source other than the uterus, manifested itself prior to delivery.

About the middle of last August I was hastily summoned to attend Mrs. C——, aet. thirty-five, the mother of several children. She was now pregnant being advanced to about the middle of the fifth month.

Upon the completion of her day's work at the wash-tub she was seized with a sudden and profuse hemorrhage. By the time I reached the house the flow had ceased spontaneously. Finding, upon examination that a varicose condition was present in the veins of the right leg, and also in those of the vulva, I expressed the opinion that the bleeding was, in all probability due to a rupture of one of these overdistended vessels in the latter situation, But I failed to discover, in the rather hurried examination I then made, the point of rupture. Mrs. C. attributed the hemorrhage, as well as the presence of a large phlegmon situated midway of the thigh (the right), on its inner aspect, to a fall received a week or two before. I directed her to remain as quiet, during the remainder of her pregnancy as circumstances would permit, and saw nothing more of her until some two weeks later, at which time she called at my office, for advice relative to the condition of her leg. The entire limb was œdematous; the veins greatly distended, and the phlegmon, before noticed, in about the same condition as when my attention was first called to it. The swelling was still hard and unyielding, presenting no indications of suppuration. During the interval which had elapsed between my visit and the consultation at my office, there had been a recurrence of the hemorrhage, but I was not called, as the flow was slight, and lasted but a short time. During the evening of the fourth day, following the consultation at my office, I was again summoned to the patient's house. She had been seized with a most violent hemorrhage. I was satisfied, upon

examination, that the case was one of placenta previa. There had been no pain, but each motion of the child increased the flow. I introduced the tampon, and sent a messenger for Dr. Reamy, requesting him to see the case with me, and upon his arrival the diagnosis of placenta previa was confirmed. Placing the woman in the extreme lithotomy position we could distinctly feel through the widely dilated os, the placenta, covering about one half the field of dilatation, and the head was plainly distinguished. The hemorrhage having recurred so frequently: the os being dilated and dilatable, and the head presenting so favorably, we concluded that immediate delivery was not only practicable, but offered the greatest security for our patient. The proposition met with a positive refusal from the husband, who declared that he would not have the life of the child thus sacrificed. Our statement that its life would, more certainly be sacrificed by delay was of no avail. We again introduced the tampon, hoping for a spontaneous termination of the labor.

At our next visit we found the husband willing and the patient anxious for instrumental aid, but upon removing the tampon and a mass of coagula, we found to our surprise that the os had contracted firmly, permitting the free passage of but one finger beyond its rigid lips. The fetal head was beyond reach, and the placental margin was alone felt, although the patient was, as at the former visit, placed in the extreme lithotomy position.

Delivery with the forceps was, of course, impossible, and, although we anticipated a renewal of the hemorrhage at any moment, it was deemed better to watch the case closely, than to attempt to deliver in the only manner feasable under the circumstances, viz., forcible dilatation and version. Pledgets of carbolized cotton were introduced, and well packed into the cervical canal, completely filling it, and the vagina was plugged as on the previous occasion. At my evening visit I found the patient restless and apprehensive; complaining of slight headache, and occasional uterine pains. The next morning I found the pain in the head still present, and more severe, as a chill had seized the patient during the night, there were present also, a rapid pulse; elevated temperature, and vomiting. I was fearful that pyemia had siezed my patient, and felt satisfied that her only chance for life lay in immediate delivery, very naturally supposing the symptoms to be due to the absorbtion of septic matter from the uterus. Dr. Reamy was sent for and coincided most heartily in the opinion above expressed.

The patient and her husband readily consenting to leave the case entirely with us, we placed her in the position chosen at previous visits, intending to deliver with the forceps, should we find the conditions favorable to such a procedure. The packing was removed, when the hemorrhage began with renewed violence. The os was less dilated than at our first visit, but sufficiently so as to enable us to distinguish the head, and

warrant us in the belief that a forceps delivery could be accomplished. The task of applying the forceps was, necessarily, a tedious and difficult one, but the effort would, undoubtly, have been crowned with success, had not the hemorrhage increased to a degree threatening our patient's life. After a hasty consultation this mode of delivery was abandoned, and the patient being etherized, Dr. Reamy suceeded in pushing aside the head and bringing down a knee, two fingers only having been passed into the cavity of the uterus. The labor was soon terminated, the uterus contracted firmly, and a careful examination of the placenta revealed no evidence whatever of putridity.

A few hours later I again saw the patient. She had experienced a decided rigor, which lasted for more than an hour, she was now restless; with rapid pulse; and head-ache. The abdomen was slightly swollen and tympanitic, and vomiting had occurred at short intervals.

I directed carbolized vaginal douches to be used every four hours, and prescibed quinia and carbonate of ammonia, in alternation, at short intervals. Whiskey, beef essence and milk were liberally administered. Notwithstanding the active treatment employed, the patient grew worse from day to day. The vomiting continued; there were slight rigors, followed by profuse and exhausting sweats; diarrhea set in; the temperature ranged between normal, or slightly below, during the sweating stage, and 105 and 105½° at the period of greatest febrile reaction. There was hebetude of mind: the evacuations took place without the patient's knowledge; great prostration, followed by coma, and death ended the scene on the eighth day after delivery. Dr. Reamy being absent from the city, did not see the patient after her confinement, but I had the aid and counsel of his partner Dr. Mitchell. I believe the record of the case confirms the diagnosis of septicemia, made ante-partum by Dr. Reamy and myself, that the absence of putridity in the carefully examined placenta, as well as in the lochia, until the disease had reached the highest point of intensity; confirms the opinion that the septic matter was not of uterine origin. What then was the source? In battling with the disease I gave no thought to the leg whose condition had caused my patient so much inconvenience, until my attention was called to it by a neighbor woman who acted in the capacity of nurse. The phlegmon before noticed, had disappeared, leaving no trace at the point where I had first observed it, but midway between knee and ankle, I discovered an abscess, identical in size and shape with the original swelling, and a little above the knee were two quite small ones. The septic matter was undoubtedly derived from the phlegmon, in which, unnoticed by me, suppuration had taken place after this.

Dr. Trush, in connection with the paper of Dr. Haight, reported as follows:

Two Cases of Placenta Praevia.

Case 1.—On the 23rd of November, of last year, I was summoned to Mrs. R. C., aged 28 years, secondipara, by reason of an attack of uterine hemorrhage, the second in her present pregnancy, now almost 8 months advanced; the first hemorrhage having occurred in July, some 10 weeks after the supposed conception; thought at the time she had miscarried, but became convinced of the contrary on "feeling life" 6 or 8 weeks later. The attack of hemorrhage had not been profuse and was reduced to a mere dribble at the moment of my investigation. The inferior segment of the urethra I found to be quite voluminous, slightly uneven; cervix intact, soft; os externum patulous, but inner orifice closed and resisting; no fœtal parts discernible anywhere from vagina; elevation of fundus about one inch above umbilicus; fœtus in oblique situation, head in left iliac fossa and breech to right above. Diagnosis: Probably, "placenta previa," period of pregnancy, about twenty-eight weeks. Treatment: Absolute rest in horizontal posture, cooling drinks, non-stimulating food and medicinally, morphine and bromide of potassium, gr. ¼ of the former to gr. 20 of the latter every 4 to 6 hours. On evening of same day hemorrhage had ceased and patient was perfectly comfortable; next day and day after, same happy condition. Ceased visiting. To be called again if hemorrhage recurred. January 2nd such a call came; this time not so much on account of hemorrhage, which was quite moderate, but because patient believed herself in labor. The latter proved to be a mistake and the hemorrhage again speedily subsided under the administration of similar remedies as in the first instance, except that small doses of ergotine were now added to the previous prescription. On this occasion I observed a peculiarity of the cervix quite novel to me: In passing the finger along the anterior wall of the vagina and having reached what I supposed to be the corresponding surface of the cervix, a prominent and somewhat resisting ridge was encountered, following which I found it to be of circular outline and encompassing an opening of about the diameter of a silver dollar; through this opening a soft, fleshy mass protruded. In labor, without a doubt, was my momentary impression, regarding, as I did, the resisting border as the external os, rendered tense by the pains and the fleshy mass, protruding placental structure. A more attentive palpation however, speedily dispelled this view. The fleshy mass I found to be the softened cervix, of undiminished length, with the inner orifice closed as before; the resisting ring, the lowermost portion of the corpus uteri proper, rendered more or less tense by tonic contraction of the circular fibers at this point.

Although not yet absolutely positive of the existence of placenta prævia, I thought it prudent to provide the patient with means for the temporary arrest of sudden and profuse hemorrhage: a cylindrical speculum,

a small bag of powdered alum and a quantity of cotton balls constituting this outfit together, with explicit instructions respecting its use. No further disturbance occurred until the 1st of February, when another false alarm of labor was sounded, not, in this instance, accompanied by hemorrhage; no such flow having been observed since the 2nd of January. On the 15th of February I was summoned to Mrs. C. for the fourth time. Labor this time certainly being in progress; the "water had broke." I found indeed that the os internum was giving way, being dilated to about the size of a silver quarter. For the first time I was now enabled to explore the presenting surface, and beheld in the entire extent of the opening, the peculiar, irregular, spongy structure, characteristic of the placental formation; anteriorly, however, about half an inch from the border of the orifice, my finger came upon a smooth surface through which I was enabled to detect, indistinctly, a hard ballotting body, evidently the fœtal head—determined to be such more definitely by the subsequent external exploration—the oblique situs, therefore, no longer existed. Liquor ammi, or a fluid of similar appearance seemed to be passing guttatim from the uterus. There was no hemorrhage. Feeling quite certain, myself, that labor was impending, I watched the patient very closely during the day, only to find toward evening that the os internum was gradually closing again; by late bedtime all indications of labor had disappeared. Next day: no changé, the watery fluid still passing away by drops. I was to be called again if, either labor or hemorrhage should supervene. On the third day toward noon, and during an unavoidable absence of some four hours, active labor rather suddenly sprung up and the child was born before my return; a midwife called in, almost at the last moment, attending the patient. I was informed that a slight loss of blood occurred with the commencement of labor, but nothing to be alarmed about. The child was small and bore evident marks of immaturity.

Case 2.—Mrs. D. F. M., aged about 32 years, had engaged me to attend her in her approaching fourth confinement, anticipated to occur somewhere near the 1st of February. On the 9th of January the husband came to inform me that "last evening Mrs. M. had observed a plug of mucus and some blood—two or three tablespoonfuls—to pass from her genitals. What did it mean? Should anything be done?" Regarding this simply as evidence of impending labor I so stated to Mr. M., remarking at the same time that he would, doubtless, soon have occasion to call me. Nothing was heard of this patient until the 11th of February, when, about 5 o'clock p. m., a messenger from Mrs. M. came to request my immediate attendance. On arrival I learned that about noon the patient had been suddenly seized with profuse hemorrhage from the womb, causing her to faint, and to be brought to bed in this condition, (a telephone message addressed to me at this time requesting my presence, bearing neither name nor definite address, could not be obeyed); that

after having been put to bed the hemorrhage gradually abated, and about 4 o'clock ceased altogether; that, however, irregular pains had appeared during the afternoon and were gradually growing stronger. A vaginal exploration at once instituted, disclosed the same voluminous cervix, with its irregular surface as in Case 1, and as the os internum was dilated to perhaps an inch in diameter, the parts above, consequently, accessible to ready palpation, I had no difficulty in determining the character of these structures; I found placental tissue everywhere, neither membranes nor fœtal parts being within reach. External palpation enabled me to detect a cephalic presentation and dorso-anterior position. Although prepared, by reason of Case 1, then still pending, for an encounter with placenta prævia, I was somewhat perplexed, for a moment, what to do. Should I apply a tampon, or turn upon the feet bimanually, or wait for further developments? In view of the absence of hemorrhage and the otherwise satisfactory condition of the patient, I concluded to do the latter: wait for developments; hoping at the same time that events would more clearly indicate the course of action to be pursued. An hour perhaps had been spent in waiting and the making of various preparations for the impending struggle, when patient called out, "Dr. my water has broke." Immediately inspecting the character of the flow, I beheld, instead of liq. amnii, a stream of blood issuing from the vagina. A digital exploration disclosed the fact that considerable progress in the dilatation of the os internum had been made, it being now fully the size of a silver dollar. Placental tissue all around was pressing into the opening, and the blood found to be descending in a steady stream. Manifestly, no time was now to be lost in cogitations, instantaneous and efficient action alone was proper. Of the several measures recommended, podalic version, by the internal method, seemed to me the most appropriate. The inner os, though still too small for the purpose, I felt confident would yield under pressure to admit of passage of the hand. Quickly, therefore, placing the patient partially upon her left side, I inserted the right hand into the vagina, and thence, after exploring the cervical ring and finding the placenta partially detached toward the right, upward in this direction, through the cervix into the uterine cavity. As had been anticipated, some resistance was encountered in the cervix, which, however, was speedily subdued. About two inches above the borders of the os internum, the fingers came upon the smooth membranes, on piercing these, the feet of the child almost fell into my grasp. Seizing hold of both, I brought them slowly down into vagina, and thence externally; Once the breech fairly in the os all hemorrhage ceased. Anxious to bring the uterus into vigorous action I now ordered teaspoonful doses of Squibb's fl. ext. of Ergot, at intervals of 10 minutes, until half an ounce had been consumed, and the uterus was found to respond vigorously, expelling in a short time the body of the child to its shoulders. Spas-

modic movements, on the part of the child, supervening, served to admonish me to complete the delivery if I would save its life. In this effort I encountered considerable difficulty, because, in the version I had inadvertently brought the abdominal surface of the child forward, and now found the arms lodged behind the pubic symphysis; eventually, however, I succeeded and extracted a deeply asphyxiated child, but which, under the application of the usual restoratives, was speedily resuscitated. No hemorrhage followed upon the birth of the child, and none, to my great delight, upon the separation of the placenta. Its detachment was somewhat tardy, occurring only after the lapse of a full half hour, but as there was no hemorrhage, and the uterus well contracted, I could afford to wait. Turning my attention now to patient's general condition, I found her, as was to be expected, exceedingly faint and weak; but with, still, a fair pulse, and which, under the influence of a few small doses of whisky, soon acquired considerable firmness. After a good rest the vagina and uterus were washed out, by means of syphon apparatus, with hot carbolized water; subsequently the patient was lifted from her soiled bed, cleaned, bandaged and generally made comfortable; all this being of course done with the least possible disturbance of her person. A careful watch was kept of the patient for some hours thereafter; happily it proved superfluous, everything remaining in the most satisfactory condition. This patient passed through the entire lying in period without an untoward symptom, and to-day, both mother and child are in excellent health only, that the former is still markedly anæmic.

These cases, though not presenting anything very unusual, nevertheless serve admirably to illustrate the diversified course pursued by cases of placenta prævia. The first of these is marked by three attacks of hemorrhage, of which the first evidently, was significant of an attempt at abortion, whether or not it also is to be credited with an Ætiological significance in the sense of Muller's theory—dislocation of a primarily normally located ovum and its projection downward upon the os internum—must necessarily remain a matter of conjecture. The second and third attacks occurred at customary periods for placenta prævia centralis. Though the placenta, in this instance, as subsequent exploration disclosed, was far from being centrally located, it had nevertheless so largely invaded the dilatable territory, that "unavoidable" hemorrhage with the onset of labor, was clearly to be expected; yet, when this event did transpire the loss of blood was so trifling as to be passed by as nothing unusual. The explanation, it seems to me, is not far to be sought; with the two more recent attacks of hemorrhage, separation of the placenta along its anterior border, had, doubtless, taken place; the subsequent dilatation was effected at the expense of this, the anterior segment of the circle, leaving the posterior, with the mass of the placenta, untouched. Whatever the explanation, the case certainly

must be recorded in evidence against the ultra aggressive theory advanced by some recent authorities respecting the management of placenta prævia. Assuredly, under circumstances like these, it seems to me preferable to temporize, arrest the hemorrhage, provide patient with means for the momentary arrest of sudden and profuse hemorrhage, and have recourse to active interference only when symptoms, hemorrhage, etc. assume a threatening character.

In Case 2, which in every sense of the term, may be designated "central," the right border, the nearest probably, being fully two inches distant from the respective margin of the os internum, only one slight hemorrhage took place prior to the actual commencement of labor, and this latter event was overdue rather than premature at the time of its occurrence. Another instance, it will be perceived, illustrating the correctness of the theory advanced by Matthews Duncan, and especially emphasized by the late Prof. Speigleberg, viz., that "unavoidable" hemorrhage in placenta prævia takes place only with the inception of labor, that, hence, even with central insertion there may be an entire absence of hemorrhage prior to this act, and that if hemorrhage do supervene at an earlier date, such hemorrhage is purely accidental.

Regarding the management of the case it might be claimed, perhaps, that, in view of the very flattering success recorded recently, especially by Hofmeister, of Berlin, for the "bimanual" method of turning upon the feet, I should have had recourse to this measure immediately upon my arrival, the os internum being then already passable for two fingers, and thus have avoided introduction of the entire hand into the uterine cavity. My reasons for adopting a different course of procedure are and were, substantially these: An attempt to turn "bimanually," would, to a certainty have occasioned hemorrhage, possibly very profuse hemorrhage, and as the version by this method occupies considerable time, the loss of blood might, speedily have reached fatal proportions before, at any rate, the flow could have been staunched by the fœtal plug, the breech of the child. In the presence of a very profuse hemorrhage I would have been compelled to desist in efforts at turning by the mode in question, and apply a vaginal tampon, the os internum being as yet insufficiently opened for the internal method, but a tampon under the circumstances would have exposed the patient to the additional danger of septic infection, and perhaps that of renewed hemorrhage upon its removal. So long, therefore, as dilatation proceeded without hemorrhage it seemed to me best not to interfere, for, with the passage adequately dilated for passage of the hand, I should be master of the situation; I should no longer be compelled, in the event of hemorrhage, to rely upon the vaginal tampon. When later, the hemorrhage recommenced, it was so profuse that only the most rapid procedure for its arrest could be entertained, viz., in my opinion, podalic version by the internal mode. The ob-

jection, that the entire hand detaches a far greater portion of placenta, and subjects the patient to a correspondingly greater degree of hemorrhage than would result from the two fingers employed in the bimanual process, is not valid, and from the fact that hand and wrist immediately upon entering thoroughly, plug the cervix and arrest the hemorrhage, which is not the case when the fingers merely operate in the os. This, of course, supposing the operation is attempted as soon as the hand can safely enter.

DISCUSSION.

Dr. Palmer, in opening the discussion on the subject, remarked that the evidence in Dr. Haight's case confirmed the suspicion that the source of septic poisoning was the uterus and not the distant extremity of the patient. The general and local conditions were certainly very favorable for such a complication to arise. A weakened condition of the patient from loss of blood, an extreme vascularity of the lower segment of the uterus, both in its body and neck, the presence of not a few large blood vessels, open sinuses, which were exposed from a detachment of the placenta, and finally, the repeated use of the tampon covering a period of some 48 hours. Some blood necessarily must have been retained around the site of the tampon, and some decomposition of the same must have occurred, not with standing the precautions taken against it, which appear to have been fully observed.

Septic absorption can and does take place from the site of a local abscess, but the opportunities for such infection are so small as compared with the local conditions present within and around the uterus in placenta previa, that it seems most reasonable to attribute the septicemia to the latter rather than the former causes.

Dr. Palmer said he desired to mention but a single point connected with the management of placenta previa, a point in practice which had been forced upon his mind a number of years since by an experience in a fatal case, and which had served him since. In 1872 (reported in Academy proceedings, Nov. 1872), he was summoned in consultation to a case of central inflammation of the placenta, the patient being extremely exhausted from repeated and profuse loss of blood. The cervix was not dilated but dilatable, the head was resting on the pelvic brim and bleeding was still going on. Stimulation was commenced, and immediate delivery accomplished by a detachment of the placenta on one side of the cervix, and by podalic version. The quantity of blood lost in and after delivery was small, but death followed its completion, in some thirty minutes. In reflecting over the case, he had thought that this patient, although almost pulseless when seen by himself, might have recovered, if immediate delivery had not been attempted, but means to arrest the hemorrhage and revive the patient had been employed. Not long after, he encountered another case in consultation where the conditions

were almost similar except that the placenta was laterally attached. There was no uterine action. The two physicians in attendance were anxious for immediate delivery by version, he himself dissenting. The vagina was well tamponed, the head and shoulders of the patient were placed low, stimulants given, a bandage firmly applied on the abdomen, the membranes ruptured, and a small dose of ergot given hypodermically. The bleeding was arrested, and in less than a half hour the pulse became more peceptible, and the uterus began to act, the head to engage in the pelvic brim, pressing firmly around the cervical ring. Delivery was finally completed by forceps, the patient making a good recovery.

He could mention other cases where a like plan of procedure was instituted with favorable results.

The point he aimed at was this: recognizing that there is no safety to the patient in placenta previa, so long as she remained undelivered, one is often tempted to hasten or precipitate that delivery, irrespective of the general state of the patient, or the local conditions to be encountered. Artificial delivery is usually accomplished under these circumstances by version. We are to remember that podalic version, as must needs be done in most presentations, implies the introduction of the accouchers hand high in the uterus, the revolving of the child within the cavity, and withal, a certain necessary amount of *shock* to the patient. Is she able to bear this shock? In good health, the shock may not be perceptibly felt, but when there is great exhaustion, it is always greater, and may, in conjunction with the losses of blood, be enough to sacrifice a life.

And not only is this shock from version greater under such circumstances, and with head presentations, but the *delay* therein not inconsiderable, if the cervix is imperfectly dilated, a very common attendant. For his part, he would prefer to postpone efforts at delivery, in an extremely prostrated state of the system, especially in head presentations, and with the cervix not fully dilated at least for an easy version; accepting at the same time the risk of a continuance of the hemorrhage, rather than make use of the *accouchement force.* In this temporary delay we are by no means to be idle. The head and shoulders are to be lowered, moderate stimulation by brandy applied.

To arrest the hemorrhage, to expand the cervix and to excite the uterus to action, the cervical canal should be tamponed. To make this little operation thorough and as secure as possible, a Sims' speculum comes into play very nicely. To further aid in bringing the uterus into action, as well as force the head of the fetus against the bleeding surfaces, making it act as a tampon from above, the application of a stout abdominal bandage is of advantage; also the judicious use of ergot; and sometimes a rupturing of the membranes.

The patient is thus, as it were, bridged over a critical period, till she is stronger, and until the local conditions become more favorable for an

artificial termination of the labor, if necessary. If the head is disposed to engage within the brim, the forceps are to be preferred to version.

The successful managment of theses case require not only great promptness of action, courage in execution but a nicety of judgment.

There are no inflexible rules to govern us in the management of all cases. The physician must be left to his individual judgment, for every case is more or less a rule to itself. What is applicable or justifiable in one case may not be in another.

Dr. Cleveland remarked, that every case of placenta previa was a law unto itself, and from the nature of the case it is impossible to lay down any definite course of treatment. In cases of the character reported by Dr. Trush, where prompt action is required, version is unquestionably the thing to be done. Turning is usually accomplished so quickly and easily that there is a great temptation to do it, but unfortunately it is frequently attended with great danger. When practicable I would much prefer tamponing firmly through the speculum and wait for the os to be thoroughly dilated and have the head come down and tampon the os. Then the vaginal tampon may be removed and labor can proceed in the ordinary way, or the practitioner can apply forceps as he may elect. But the tampon can only be applied to a certain class of cases; in other cases the hemorrhage may continue for an indefinite period, when it might be clearly impracticable to apply the tampon, either it would be hardly sufficient to control the gradual oozing that is going on, or if it did it might be at the risk of developing septicemia, as seemed to have been the case in Dr. Haight's patient.

Dr. Miles said, that after reflecting on the report of Dr. Haight's case, he was led to believe that the septicemia was developed during the slow process of dilatation of the uterus, for evidently decomposed blood could have been absorbed that time.

Had the doctor possessed greater persuasive or mandatory powers and effected as he desired a more rapid dilatation and speedy delivery, his patient might have fared better. In such cases the physician and not the patient should be self asserting.

As placenta previa occurs only about once in every 573 cases, the experience of the ordinary obstetrician in such cases is necessarily limited; and as such cases are so dissimilar on account of the site of the placental implantation his action must depend upon the indications in each individual case, whether there is great hemorrhage with slight dilatation of the os, or the os fully dilated, whether the head presents and can be grasped by the forceps, or version advisable. The management of the placenta also may become an important consideration. In most cases the life of both mother and child will depend upon prompt delivery. Hence it is that detailed reports of cases is of great interest and value.

He presented the following cases: "In September, 1876, I was called

in consultation by Dr. W——, to see a case of placenta previa. Patient's age, 25 years; mother of one child; pregnant eight months; had uterine hemorrhage for past four weeks, when labor with alarming hemorrhage came on. I found her exhausted from the loss of blood, almost pulseless, extremities cold and surface as pallid as death.

The uterus was dilated sufficiently to admit the hand, which found the placenta covering the os like a hood; central implantation; vertex presentation, R.O.A. I rapidly pushed my hand up, detaching the placenta from the right side of the uterus, elevated the head of the child, passed the face grasping the feet, and with my left hand on the abdomen of the mother and against the back of the child, speedily effected podalic version. Version and delivery was easily accomplished in consequence of the relaxed and flacid condition of the uterus.

The placenta was removed without difficulty soon afterwards, and both mother and child made a slow recovery."

"November, 1882 I was called in consultation by Dr. R. to see a case of placenta previa. Patient aged 30 years; mother of five children; preceding last pregnancy had aborted at the sixth or eighth week. Period of utero-gestation nearing the seventh month. Has had uterine hemorrhage more or less of the time the past three weeks, which was occasionally accompanied by labor pains.

During past few hours had considerable and threatening hemorrhage, some labor pain with slight dilatation of os. On digital examination the os dilated sufficiently to admit two fingers; found the placenta covering the os, implantation principally to left side, vertex presentation, R.O.A., membranes not yet ruptured. An effort was at once made to perform podalic version by bi-manual manipulation before the membranes ruptured, but during the operation the membranes ruptured; yet the procedure was continued, detaching the placenta to the right with two fingers, grasping a leg and effecting evolution, after which delivery was soon accomplished.

The premature and depleted child lived nearly two days, mother made a slow recovery."

In placenta previa there is an increased hypertrophy of the lower portion of the uterus and upper portion of the vagina in comparison to location in fundus, in some cases obliterating the cul-de-sac. The os and cervix, owing to large vessels communicating with the placenta, besides being unusually thick, will impart a doughy feeling to the finger, and this condition will also be found in the upper portion of the vagina.

When the placental implantation is lateral the hypertrophy of that side of the uterus and vagina is quite distinctively marked. In the last case reported, several days before the patient was confined, this lateral hypertrophy was quite apparent and the case then diagnosed as left lateral placenta previa, which was verified on delivery.

The speaker called especial attention of the members of the society to

this condition of hypertrophy of the lower portion of the uterus and upper portion of the vagina as an important diagnostic symptom. It is of great value in making an early diagnosis where hemorrhage exists and before the os is dilated sufficient for intra-uterine exploration, and thus enables us to more intelligently manage such cases and be on the alert for dangerous hemorrhage.

Dr. Wenning said that in an experience of twelve years he had but once had the opportunity of attending a case of placenta previa, and this was in the first year of his practice. It occurred in a young woman who, in consequence of unusual exertion in lifting a tub, miscarried at the seventh month. She was attended by a midwife, who, on account of the severe hemorrhage that set in, called in the speaker. He found the placenta located almost centrally, the greatest point of attachment, however, being to the left of the os. The hemorrhage was controlled by the internal use of ergot, the attachments gradually loosened by the fingers and the tampons resorted to. By this expectant plan the os dilated sufficiently until the placenta and fœtus came away, the latter being born dead, and the woman made a good recovery. There was nothing of special interest in this case, and he only mentioned it as an illustration in corroborance of the remarks made by Dr. Palmer, that any meddlesome interference may be frequently more productive of mischief than temporizing and waiting for the efforts of nature in securing a safe delivery.

Dr. Davy remarked that he was not so certain of the origin of septicemia in Dr. Haight's case. Just after listening to the report he had concluded with the other speakers that its source was in the uterus, so favorable had all the conditions seemed for such infection; but, upon reflection, he had been compelled to admit that the phlegmonous inflammation of the leg might in truth have been the cause. He had been led to this conclusion mainly by the fact that the discharges from the uterus and vagina had at all times been devoid of smell; as putridity is one of the necessary conditions to septicemia, he thought that at least some evidence of it should be present. It did not by any means follow that because putridity is present septic infection shall result, for though absorbing poisonous matters, the system may be strong enough to guard against infection, and the condition in question be very much delayed or prevented altogether. If, in the absence of any knowledge of decomposition in the pelvic discharges, the speaker could obtain evidence of putridity about the abscess in the leg, the point might be considered as settled. Under the circumstances, however, he was not prepared to say, with most of those who had discussed the subject, that the septicemia was of pelvic origin. Authorities agree that, though of rare occurrence, it is plainly possible for septic infection to arise from a source not exposed to the atmosphere. The intestinal canal and (sometimes) urinary bladder are full of

the bacteria of decomposition; though the gastric juice is supposed to be antiseptic, the matters contained in the intestines are far more capable of setting up decomposition than the air itself. The want of uniformity in the condition of the contents of the bladder in this respect shows perfectly well that they are not fertilized by the air. From this, without other evidence then, it is plain that the germs of decomposition do find their way into the circulation and through the various structures of the body, multiplying wherever fertility of soil will grant them a resting place, or weakness of the part will enable them to form a nidus. In this way could these infinitesimal spores reach the region of a bruise, and thus could a few straggling germs, in a disabled system, accomplish what it perhaps would take hundreds or thousands to do where the body is healthy and robust. The conditions entailed by placenta previa are peculiarly favorable to the production of septicemia, and it must be admitted that, under the circumstances, the causes of this disease need not be so potent. That the abscess mentioned by Dr. Haight as the cause of the fatal trouble was secondary formation, the speaker thought untenable.

As regards any definite law for the management of placenta previa, he agreed with the other members that it would be difficult to formulate such a law. The authorities are pretty well settled about the propriety of bringing on labor when the bleeding occurs after the seventh month of utero-gestation. In cases where the hemorrhage occurs before that period, palliative measures such as rest, astringents, the tampon, etc., should at least be tried. When the diagnosis of placenta previa has been established, Lusk holds it to be proper to bring on labor at once without regard to any particular stage of pregnancy; and, considering the constant danger in which such a patient is placed, this may be looked upon as the least of the evils. As to the use of forceps in such cases the speaker believed that much advantage could hardly be gained from them, as the loss of time thus occasioned would prove too hazardous for the patient. A central implantation of the placenta is very rare, and if the finger is passed into the os anteriorly and to the left the margin of the placenta will soon be reached and the fetal head can be felt. Very often simple rupture of the membranes will be sufficient to render the pains more active and thus stop the hemorrhage. In case, however, active pains do not follow, version is to be brought about as speedily as possible. This, he thought, could be best accomplished by the introduction of two fingers, or the entire right hand if necessary, while assistance is rendered with the left applied to the abdomen.

The speaker had had three cases of placenta previa though he had attended nothing like the number of lying-in women to justify such a share.

The first case was one of central implantation and came into the speaker's hands towards the close of the fifth month of utero-gestation.

Hemorrhages had been recurring from time to time for about five weeks, and the woman was very anemic. During a hemorrhage which was feared would prove fatal he was called. The os was small, hard, and resisting, and all attempts to dilate with the fingers proved futile. Tamponing was only of temporary service, and every effort was directed towards speedy delivery. For some cause or other, turning was not resorted to, but, with instruments improvised at the farm house where the case occurred, the head was opened and removed piecemeal. The exhaustion from loss of blood was so extreme that the consulting physician, Dr. Kinkaid of New Richmond, Ohio, believed she would certainly die. She recovered, however, but her convalescence was slow and protracted.

The second case had progressed as far as the begining of the eighth month when bleeding occurred. The patient commenced to bleed at 6 a.m.; at 8 a.m. she was pallid and fainting. Dr. Stanton was called to assist the speaker and the two succeeded, in less than an hour, in dilating the os sufficient to insert the hand and turn. The hemorrhage was checked at once and the labor proceeded without further trouble.

The third case occurred on April 19th, 1882, when the patient had arrived at term. She was 26 years old and robust. This was her third confinement, her two previous labors having been tedious. The hemorrhage had commenced two days before the speaker was called, and was getting very profuse. An examination revealed a placenta previa diagonally implanted. The placental margin in the left anterior direction extended only about an inch above the os. The os was dilated to about the size of half a dollar; internal os quite as small. At this time, and during dilatation of the os with the fingers, the bleeding was very profuse. As soon as the os was one and a half inches in diameter the placenta was separated and the membranes ruptured. The obliteration of the internal os took some time, but as soon as the head commenced advancing all hemorrhage ceased and birth followed almost immediately. The placenta was adherent and had to be separated with the hand.

Dr. Trush, in closing the discussion, remarked that it was very evident from the testimony advanced by members respecting their experience with placenta previa, that no one single plan of management was suited for all cases. Under certain peculiar circumstances, a purely expectant plan had given good results better, very probably, than could have been attained by any other procedure; and so on throughout the entire list of measures recommended. Even the cranial forceps had its place of superior efficiency, in placenta previa. He could not, however, assent to the use of this instrument within the uterine cavity with the placenta still more or less completely occluding the cervix and covering the advancing head. Under such circumstances he should always prefer podalic version and that as a rule by the internal method.

Respecting the source of the septic infection in the case of Dr. Haight,

he also, like several other members of the Society who had spoken upon the subject, regarded the parturient canal, as such source and not the phlegmon upon the thigh; the primary cause of the infection being, doubtless, the vaginal tampon.

ACADEMY OF MEDICINE IN IRELAND.

Obstetrical Section.

The Obstetrical Section met in the College of Physicians on Friday evening, January 26, Dr. Denham, President of the Section, in the chair.

Exhibition of Specimens.

Dr. Atthill showed a large subperitoneal fibroid which he had recently removed from a patient by abdominal section.

Mr. Abraham showed a specimen of ectopia of viscera in a fœtal male cat of about five weeks. The heart, liver, stomach, and greater part of the intestines were quite extruded from the body cavity through a nearly central opening in the abdominal wall. A few membranous shreds could be traced from the margins of the opening over the viscera. No other abnormalties, and the membranes were nowhere adherent. Mr. Abraham also showed an example of dichotomy in the left foreleg of a sheep. The bones of the two fairly-developed feet started from the carpus. They were subequal in length, but the outer one, probably the accessory, was the slenderer of the two, and wanted also some of its flexor and extensor tendons. A normal integument covered both feet as far as the metacarpo-phalangeal joints.

Dr. W. J. Smyly reported a case of

Induction of Abortion at the Fifth Month Necessitated by Hæmorrhage.

He concurred in the opions of Drs. Priestly, Ahlfeld, and others, that the indications for the induction of abortion as distinguished from the induction of premature labor had not been laid down with sufficient precision. He could not, however, agree with Schrœder that the induction of abortion should never be necessitated in cases of hemorrhage. Nor did he believe that where this was prolonged abortion necessarily occurred spontaneously. The patient was a pluripara, and since the occurrence of a previous miscarriage had suffered from symptoms of endometritis. In the month of February last she again became pregnant, and for four and a-half months subsequently she was subject to frequently recurring hemrhages, which at last became so frequent and so profuse as to necessitate the emptying of the uterus. Labor was accordingly provoked by the in-

troduction of a sponge tent, and accelerated by Barnes' dilator. The ovum presented a peculiar appearance, owing to the enormously hypertrophied decidua, the result probably of the endometritis. The fœtus was of a size corresponding to the period of pregnancy, and showed signs of commencing decomposition. A large quantity of firm laminated clots preceded and followed the expulsion of the ovum. The patient died of septico-pyæmia on the thirty-second day after delivery.

Dr. Macan said that the induction of abortion was clearly justifiable in certain cases. However, in cases of molar pregnancy, or of a certainly dead embryo the term "procuring abortion" was scarcely a right one. Strictly speaking, the phrase was only applicable where a diagnosis was made, the fœtus was living and capable of going on to its full term.

Dr. Neville agreed with Dr. Macan. Whenever excessive hemorrhage threatened the mother's life in early pregnancy the steps which should necessarily be taken to stop the bleeding were also those which would usually accelerate abortion. In the presence of great hemorrhage such steps might be properly taken, even though the embryo could in no way be ascertained to be dead. Dr. Smyly's case did not seem to him one to which "induction of abortion" was applicable. It was rather one of a threatened abortion, in which the amount of bleeding rendered accelerative measures advisable.

Dr. MacSwiney thought that in Dr. Smyly's patient conservative measures had been too long persisted in to the detriment of the mother. Abortion might justifiably have been sooner hastened.

Dr. A. Henry said that in this class of cases expulsion of the ovum should be expedited with the view to stopping dangerous hemorrhage and preventing an opportunity for auto-infection.

Dr. Smyly, in reply, said that the case cited in his paper was not one of a molar pregnancy. Decomposition having only commenced in the fœtus, it could only have been dead for two or three days. Had abortion been brought on any sooner the fœtus might have been born alive. He still thought that the nature of the case justified the title of his paper.

Dr. C. E. FitzGerald read a paper on

The Connection Between Ocular Diseases and Certain Affections of the Female Generative Organs.

The President said he had lately under his care a child of only eight years old who, he had no doubt, masturbated. She had never menstruated, and suffered from organic brain disease. One question was whether the practice was not sometimes induced by some derangement of the general health affecting the brain.

Dr. Macan remarked that the question of masturbation was a most difficult one, and he hesitated to say what he heard about it. Without the patients's own confession they could not be absolutely sure about it,

but there might be evidence sufficient for a moral belief. The symptoms which he took as signs of masturbation in an unmarried woman were flabbiness of the vulvæ, great relaxation of the parts, and the possibility of palpating the ovaries. He had in such cases palpated them with as much ease as in a woman who had had half-a-dozen children. Besides, there were the ravenous appetite, the muddy complexion, and the entire moral aspect of the woman which proclaimed the Onanist. It was necessary to get a confession from the woman, because treatment was powerless until they were able to tell her that the injurious practice must be stopped.

Dr. Henry Kennedy said that in his experience masturbation among females was very general, but had not found much difficulty in getting them to admit it. He had rather found that both males and females who were addicted to the practice would admit it if properly asked. The question of connection between such practices and diseases of the eye was a very difficult one, and almost required a man to be at once a specialist in two departments. The combined knowledge of oculists and gynecologists might determine the question. The immediate effects of the practice were confined to the external parts, and no disease in the proper sense of the term was set up in the vagina or in the uterus. The more remote effects were not confined to the eye alone. The disease *petit mal* had directly resulted from the habit in both men and women. He had cured *petit mal* in both sexes by insisting on the practice being given up. Amongst the signs were drooping of the eyelids, dilatation of the pupils, and complaints of loss of vision; and inquiries then elicited the fact that the practice was resorted to. He did not think that inspection of the vulvæ would make it certain that the habit existed. He had known hypertrophy of the parts to result from the practice.

Dr. MacSwiney was sceptical as to the general prevalence of masturbation on the part of young girls. There should be the utmost caution before entertaining a question of the sort respecting a young girl brought to a medical man for advice. Downcast eyes and large pupils and muddy faces were not sufficient to justify the conclusion that an examination should be made. He thought the question with respect to that practice was whether it was a disease of the uterus or general organs. It might go on for years without any visible signs of the sexual organs at all. Did boys who masturbated suffer from analogous ocular affections?

Dr. Benson said it was difficult to understand how so many eye affections as had been mentioned could be produced by one common cause, and it seemed more reasonable to suppose that both the masturbation and the ocular affection were in common the result of some nervous disease. They knew that a very large number of lunatics had been found to practice masturbation.

Dr. Swanzy said there were other irritations of the sexual organs be-

sides the one mentioned which gave rise in females to disease of the eye. In the end they might find that both the masturbation and the ocular affection were the result of one and the same cause—namely, an affection of the base of the brain. He had seen a patient in whom the menopause combined with mental excitement had applied to him to determine an attack of optic neutritis terminating in atrophy. In this case the cessation of the catamenia had appeared to act deleteriously, converting what had been previously an habitual congestion into an inflammation. Five years ago he read before the Obstetrical Society a paper in which he tried to show that in young girls of from eleven to fifteen years of age cases of iritis occured, that disease being very rare in such subjects except in cases of inherited syphilis. He had never seen a case of iritis at that time of life in boy, and he could hardly believe that those cases of iritis were not due to some disorder of the generative system. Another very remarkable condition was hysterical amblyopia resulting from disorder of the uterus. There was a peculiar form of it which occurred in young girls presenting no opthalmoscopic signs, but in whom central vision was very much decreased, and there was great contraction of the field of vision. He had under his care a case of that kind connected with the tardy appearance of the menses. She first came under his care, æt. 17, the menses not having then appeared, and her vision being much affected. In six month's time the eye symptoms were relieved. The other day, her age being 19, her first catamenia appeared, and she was then attacked with low vision and contracted field of vision, and now, after a fortnight or three weeks, she had quite recovered.

Mr. Story said his impression was that nothing definite had been proved in this matter. That there was a connection between the uterus and the eye it was true, just as there was connection between the uterus and every other organ; but that there was any peculiar or functional connection he did not believe. It was proved, however, that disordered menstruation had an effect on the phenomena of vision, but besides anomalies of vision, it produced disorders in other portions of the system. He had never seen a case of hysterical amblyopia. He did not disbelieve in the affection, but he did not believe that it occurred without there being a definite physical cause for it. He could understand absolute loss of vision being produced by hemorrhage upon some portion of the optic nerve behind the eyeball, which might afterwards be absorbed and vision restored. The proofs given in the paper of Dr. Mooren, which Dr. FitzGerald had made the basis of his paper, seemed to be unsatisfactory as regarded the alleged condition between affections of the uterus and affections of the eye. The process of causation assigned for the production of the affection of the eyes seemed most elaborate and far-fetched, and many of the cases quoted, when critically examined, failed to support his contention with cause and effect.

Dr. Doyle had been startled by the statement in the paper as to the frequency of masturbation among females. He did not believe the connection between masturbation and eye affections to be made out on the evidence adduced.

Dr. Neville objected to masturbation being regarded as a disease of the generative system. Was it a disease at all? He did not think it was. It was very often a vice, while in other cases it was symptomatic of disease rather than a disease in itself. Sometimes it originated in a local source of irritation, such as acrid discharges from the genital organs, or in boys by a long prepuce, while sometimes it was due to distinct or latent nervous diseases. Thus masturbation was associated with epilepsy and insanity, not in a casual relation, but as an individual symptom of the nervous disorder. It no doubt was often an early or premonitory symptom in such cases. Eye affections, such as atrophy of the optic nerve, were naturally here to be looked on as symptomatic; also it must not be forgotten that the apparent connection between affections of the generative system and of the eye might merely be coincidences. To prove the casual relation of the former it must be shown that they preceded the affections of the eye, that the menstrual molimena influenced the course of the eye affection, and also that their cure was essential as a part of the treatment, at least of the latter. It was certain that disease of the generative organs with disordered menstruation would react on a disease of the eye as on the rest of the system, but this reaction was not to be confounded with causation. Nothing had been proved to his satisfaction with regard to this alleged causation.

Dr. FitzGerald replied, contending that Dr. Mooren's proofs in the form of cases had not been fully represented in the American translation; in the original German they were more full and convincing. The whole question was a suggestive one, and worth more extended study. But he had not meant to imply that there was any special eye disease set up by disease of the uterus or ovaries. He believed that masturbation induced eye disease in boys just as well as in girls.—*Medical Press.*

A Good Infant Food.—Dr. Sherry, of Delafield, Wis., makes this contribution in a recent number of the *American Journal of Obstetrics*, I have tried the following mixture as a substitute for mothers milk in a number of cases, and it has always proved very successful; so much so that I have felt encouraged to advise its use. There is nothing original about the mixture. I direct the nurse to add a pint of barley water to an ounce of *pearl barley*, and allow it to cool, and then strain it.

One third of a pint of this barley water, and two-thirds of a pint of fresh undiluted cow's milk, are mixed, and sweetened with a teaspoonful of milk of sugar.

It is very important that common sugar be not used.

We have here a mixture very closely resembling human milk in color, taste and consistence, and I have learned to rely upon it in great confidence.

ST. LOUIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY.

Stated Meeting, February 15.

The President, T. L. Papin, M.D., in the Chair.

Dr. L. Ch. Boisliniere read the following paper on

The Treatment of Chronic Uterine Affections.

It must be admitted that in the management of special diseases there has been of late a growing tendency to lose sight of the broad principles of pathology, and to indulge in narrow views and methods, forgetting that specialty is the lowest degree of the art, unless enlightened and guided by a thorough knowledge of general pathology. It is against the exaggeration of this tendency that I wish to enter here my protest.

The time has come when the specialist should pause and ask himself if he has not specialized his knowledge too exclusively; if some of us, for instance, have not fallen into the ways of too much local gynecology, and neglected, to a great extent, in treating our patients, the various resources furnished by therapeutics and hygiene?

Prof. Heinrich Fritsch of Breslau, has lately noticed the tendency to employ "uterine surgery" more and more in place of medicinal gynecology. He remarks also that now almost every diagnostic or therapeutic innovation in gynecology is a new surgical manipulation.

Let us pause for a while and consider if we have not often, by our local methods of treatment, fretted and tormented beyond measure the uterus —that inoffensive little organ.

The uterus is a transitory organ; its functional activity lasts about thirty years. After performing the functions of menstruation and gestation, it falls into a complete repose. It awakens at puberty, and slumbers at the menopause. There is not in the economy another organ analogous to the uterus. It is engrafted on the organism as a sort of parasite, receiving all the influences of that organism which sustains its life.

If the influences furnished to the uterus by the parent organism be healthful and normal, its life is healthy and normal. If these influences are deficient, or contaminated by some morbific principle, the life of the uterus becomes affected and its functions diordered.

What are those agencies or influences which can, by their continuance, thus affect the uterus, and become the principal causes of its chronic affections? These are the diatheses, and also the alterations in the quality and quantity of the blood furnished to the organ. Functional and structural changes will result from these alterations.

The proposition that it is intended to maintain in this paper is, that in

chronic affections of the uterus, most frequently, the disease is primarily in the organism, and the lesion secondarily at the uterus; although, it must be admitted, that in a limited number of cases the lesion may be primarily at the uterus, and the disease, through sympathetic irradiations, may be secondarily in the organism.

I therefore exclude from this study all the acute, all the surgical diseases of the uterus, all its traumatisms—such as laceration of the cervix and perineum, the fistulæ, etc., and all the tumors and neoplasms, although some of the latter may occasionally be benefited and even cured by agents affecting the condition of the blood and its distribution to the uterus.

In the surgical diseases of the uterus, we must all admit that active interference is very often imperatively demanded. Whilst yielding to this legitimate demand, I may express the hope that greater moderation and more deliberation may be exercised in deciding upon and selecting the best procedures, and also that greater fairness may be displayed by operators, in relating failures as well as successes. In this matter, if all the operators would have the fairness displayed by Dr. G. J. Engelmann, who has reported his failures as well as his successes, we would have a more reliable basis on which to establish a comparison between the results obtained respectively by the medical and surgical treatment of uterine affections.

I believe that, unless we admit the importance of constitutional influences in the causation and maintenance of many local lesions, a permanent cure of these lesions will not be obtained. Galen has said: "*Est uterus affectus ita ut corpus.*" The uterus is affected like the body.

However, I would not be understood to say that no local treatment should ever be resorted to. The lesions, when once established, should be properly treated by local means. These lesions are often a source of irritation, and often a drain which adds to the patient's losses, and, by a morbid solidarity, re-act on the economy, especially if there be chlorosis present. This will be increased, for chlorosis will often create more chlorosis.

The local lesion should therefore be treated, and a temporary relief only will be obtained in all the cases where the lesion is not primarily at the uterus. In the very rare cases where it is primary, I admit that the lesion may be permanently cured by topical means exclusively. But, I re-assert that when the cause is general, relapses will be the rule, and that no permanent relief will be obtained until the morbid conditions of the blood have been corrected. Then will often the local lesions disappear spontaneously, or with very little topical treatment.

I can no more look on inflammation of the os and cervix uteri as a primary disease, causing derangement of the general health, chlorosis, gastralgia, neuralgia, etc., than I can look on a gouty toe, a rheumatic

knee-joint, or an enlarged strumous gland, as the primary diseases causing rheumatic fever, scrofula, etc. Such was also the opinion of Rigby.

To illustrate my position, I take the case of a patient with syphilitic iritis. He falls into the hands of a narrow-minded specialist, who treats him by local applications only. Neither instillations of atropia in the eye, nor any other topical application, will ever cure this form of iritis, until the patient, in the hands of a man with broader pathological views, shall be placed under the influence of mercury and iodine. Then the cure will be rapid and permanent. The instillation of atropia in the eye will, however, be continued, not with the view of obtaining a cure of the disease, but in order to remedy one of its worst consequences—permanent adhesions of the iris.

There are cases of strumous ophthalmia or otitis, or scrofulous naso-pharyngeal catarrh, which no exclusively local applications will benefit. These cases will rapidly improve with cod-liver oil, iodine, iron, and hygienic measures, after topical treatment has been discontinued.

It may be asked, what are the chief general causes upon which depend functional and structural changes in the uterus? These causes are mainly alterations in the quality and quantity of the blood supplying the uterus and its appendages, and also the morbid diathesis giving certain specific characters to the blood.

One of the most frequent expressions of alteration in the normal condition of the blood is chlorosis. The influence of this alteration of the blood on the nervous system will explain the production of local lesions, such as ulcerations and catarrh of the uterus. Chlorosis acts in diminishing the innervation of the uterine system, perverts its secretions, and, from a morbid functional disturbance, leads to a phlegmasia of the mucous membrane. Andral states that whenever the principal agents of life, namely the blood and the nervous system, no longer nourish and stimulate the organs in a healthy manner, the vital force of aggregation which unites the different molecules of the living tissues loses its physiological intensity, hence follows diminished cohesion of those tissues, and their softening.

The above views give, it appears to me, a true explanation of how ulcerations of the cervix, chronic endometritis and uterine catarrh are produced, and explains also the frequent formation of peri-uterine phlegmons and cellulitis as a complication of chlorosis.

Claude Bernard, in his well known experiments on the section of the great sympathetic nerve, has demonstrated the effects of a perturbation of vascular innervation in producing congestion, phlegmasia and suppuration. This perturbation is the source of the menorrhagia, much oftener the result of chlorosis than of true plethora.

Hence the great importance of correcting by therapeutic means the chlorsis, which, if not corrected, will perpetuate the local lesions and

the tendency to continually renewing menorrhagia. Local means, in this condition, will prove quite unequal to the task of curing the local lesions.

Chlorotic patients present a variety of indefinite neuralgic pains. These pains are not always an expression of local lesions, because they greatly vary in their location. In these cases it may well be said that pain is "the prayer of the nerves for healthy blood," as expressed so beautifully by Romberg.

Listen to that prayer, grant the request of the nerves, by supplying them with healthy blood, and the neuralgia, the cardialgia, the hemicrania, the hystero-epilepsy, and the numberless ovarian pains, will vanish in proportion as the blood grows richer, and harmony will then be restored to the generative sphere.

Next in frequency to chlorosis are the different diatheses, in producing chronic affections of the uterus.

The most important of these is the strumous or scrofulous diathesis. This condition begins early, and is the cause of the rebellious leucorrhea, so often itself the origin of sympathetic chlorosis. The lesions produced by this diathesis, at first limited to the follicles of the cervix, as first shown by Morgagni, gradually gain the parenchyma of the organ, which subsequently becomes hypertrophied and hyperplastic.

At other times, erosions and granular ulcerations become manifest, and are producing more or less discharges, which, under various circumstances, becoming suppressed, are replaced by inflammatory exudations about the broad ligament and the ovaries. Pelvic cellulitis is a frequent complication in the chain of morbid changes produced by the strumous diathesis.

The indications are, therefore, to correct this morbific element, in order to obtain a permanent cure of the local lesions. A purely local treatment will never remove the lesions resulting from the influence of a strumous diathesis.

The same may be said of the influence of the herpetic, the tubercular, scorbutic or hemorrhagic, and of the syphilitic diatheses. Each should be met with the treatment best adapted to its nature.

Much importance in these cases should be attached to hygienic measures—to hydro-therapeutics, to the massage, to change of air and climate, and great attention to dietetics. Under these influences, the cardialgia, the nervous palpitations, the meteorism, the hysteric symptoms, the hystero-neuroses, so common an escort to chlorosis, will be much mitigated and finally cease.

Lastly, I must consider the alterations in the quantity of blood supplying the uterus and its neighboring organs as an important factor in the causation of chronic uterine affections.

Subinvolution is one of the most frequent pathological conditions which can be referred to that increased blood stasis, and predisposes to hypertrophy and subsequent areolar hyperplasia—the so-called chronic

metritis. Dr. T. Gaillard Thomas, in his admirable "Treatise on the Diseases of Women," remarks that this condition explains the fact that "so large a number of women with uterine affections refer their illness to child-bearing, and that so many who were well until that process remain invalid afterwards. These hyperplastic and subinvoluted uteri were those which chiefly furnished Lisfranc's cases of 'engorgement,' which hundreds to-day are treating with powerful caustics as parenchymatous metritis."

The source of the evil is an excessive supply of blood to the organ, and until this is diminished all local interference by leeches, scarification and blisters will only palliate the condition until a thoroughly depletory plan of treatment is adopted, consisting chiefly of those agents considered most active in removing the passive congestion of the portal circulation, such as mercurial and saline purgatives, followed by iodine and arsenic.

Local depletion will have been of temporary service in these cases, but there will be relapses, if no general treatment has been persevered in for some time.

An opposite condition to subinvolution is super-involution or uterine atrophy, supervening during the child bearing period. This subject has been lately very well treated by Dr. W. Coles, whose paper on this subject is full of suggestions.

Super-involution will not entail great uterine suffering, but is accompanied by very peculiar nervous symptoms, which should be treated, as well as the more or less complete amenorrhea which follows it. The permanganate of soda or potash, general tonics, and especially electricity applied to the interior of the womb, may remove or correct this condition. Electricity seems to stimulate growth. An infantile uterus, under the above agencies, will grow to the size of a normal uterus—a very curious fact and well ascertained.

The abnormal supply of blood above noticed may reach the ovaries, producing a state of venosity, or rather varicosity of the ovarian or pampiniform plexus, which, when excessive, may rupture, or, by a process of stillicidium, pour blood into the retro-uterine space and form a pelvic hematocele, usually in Douglass' cul-du-sac.

It is only by the removal of this venous stasis that the danger can be averted. We should advise here a combination of local and general depletion, and especially frequent large doses of bromide of potassium. The ovarian dysmenorrhea, a frequent complication of chonic ovaritis, will be thus relieved.

A singular symptom to be occasionally noticed in those cases of chronic ovaritis, is what might be called seminal losses in the female, brought on without any provocation on her part and accompanied with marked orgasm. The patients will present partial or complete frigidity in the sex-

ual act, and have no or only little desire for it. They will consult you for this frigidity, and make to you the above revelation. Of course, this emission is furnished by the vulvo-vaginal glands, so active in coition and parturition, and is the cause of the greatest annoyance and debility in the patient, as the discharge and the orgasm are repeated several nights in succession, and may take place even during the day, in the waking state and without desire or co-operation on the part of the patient. I consider this condition a very grave one, as it may lead to epilepsy and insanity.

For the relief of it I have found the greatest benefit in repeated doses of the iodide of mercury and large doses of the bromide of potassium. No local treatment can be suggested for this condition except blisters in the iliac fossa, dressed with mercurial ointment; measures which deplete the portal circulation and its tributaries, hydrotherapeutics, massage, etc.

Frigidity, another phase of ovarian functional disturbance, is the normal condition of all women suffering with chronic uterine affections. Frigidity, to a more or less degree is also quite frequently met in women apparently healthy. The truth is that the majority of women have no strong sexual desire unless under great solicitation. A passionate woman is the exception. But when the frigidity is absolute, it suggests great ovarian atony, and should be remedied by general tonic and hygienic measures.

These patients should be advised to carefully conceal the fact of their frigidity from their husbands, because sooner or later it will lead to an alienation of conjugal affections. The husband will be tempted to look elsewhere for more fervid embraces. These women should pretend to receive the pleasure which they do not feel. Woman is affectionate, tender, devoted, but not, as a rule, sexually passionate as man or sensational novel writers, without ground, suppose. Man is the active, creating, woman the passive, nourishing principle. Hence, sexual excesses debilitate the man, not the woman. He who gives loses more than she who receives. "*Plus est in dando quam in accipiando,*" as the old school of Salerno has it.

In ending, allow me to say a word of caution in speaking of the prognosis to be expressed in all cases of chronic uterine affections. The prognosis should be very guarded, avoiding all flattering promises of a speedy cure. Call time into consultation, remembering that chronic diseases require chronic remedies.

Too encouraging promises should not be offered, especially for the cure of sterility, as this condition is very seldom cured after it has lasted more than five or six years.

If it depends upon uterine flexion, section of the stenosis will sometimes remedy it. This section will, however, almost always, if well performed, cure the accompanying dysmenorrhae, but not always the sterility, as formerly fondly believed.

The chief cause of the sterility must be attributed to some constitutional condition (occasionally to atresia of the Fallopian tubes). The cure of it is chiefly to be sought for in general tonic and hygienic measures, electricity, etc.; also by curing the sterility of the husband, and by procuring for the patient another husband after the death of the first.

Allow me to end this paper by the following conclusions:

The late excessive tendency to specialize has led us to attach, in uterine affections, too great an importance to the lesions and not enough to the general condition.

Secondly—The morbid influence of the constitution on the uterus should be considered first, and the reciprocal influence of the uterus on the organism should be considered as secondary.

Thirdly—The uterus does not lead an isolated life in the organism, but it is only a link in that harmonious chain constituted by all the organs, and if the action of that chain be disturbed, there will be suffering in every organ constituting the chain. There will be suffering in the uterus, as well as in any other organ, but not more.

DISCUSSION.

Dr. Papin remarked that he was glad to have heard the views expressed by Dr. Boisliniere, and he agreed fully with him that every specialist ought to have a preliminary training as a general practitioner before devoting himself exclusively to one branch. It is absolutely essential that a specialist build upon the foundation of a thorough medical education, together with practical experience. Without this preliminary training, the young specialist is disposed to take a one-sided, and often very erroneous view of disease. The essayist had mentioned a case of iritis by way of illustration, and singularly enough had described a personal experience of the speaker in regard to this very disease, in which a young oculist had made a very serious blunder. The latter physician, thinking only of the eye, had treated a case of iritis in a gentleman friend of his without any reference to the constitutional condition of the patient, and had hence overlooked the fact that he was the subject of constitutional syphilis. The result was, that the patient at the end of three weeks quit the oculist and came to him, when he was speedily cured by appropriate constitutional remedies.

Dr. S. G. Moses said that he considered the paper read by Dr. Boisliniere not only an able production, but a most valuable one. He was particularly gratified at the very conservative and timely views expressed by a gentleman so well known in the profession and in the field of gynecology. He hoped that the paper would be extensively read, and it was unnecessary to say it could not be read without profit.

Dr. McPheeters desired to congratulate Dr. Boisliniere upon his very timely remarks; he considered this a day of hyperspecialism. There are too many young men who rush into specialism without a previous general

training, and who are therefore naturally prone to overlook everything except their specialty. Such men look at every malady through the perverted optics of the specialist, and hence fall naturally into gross errors of both diagnosis and treatment. He agreed heartily with Dr. Papin, that before a man can become an enlightened specialist, he must have devoted some time to the general practice of medicine; he must be a practical man, and finally drift into the one particular branch which circumstances and his peculiar tastes and skill best adapt him to follow. Such a man has a solid foundation upon which he may build, and under such circumstances will prove a blessing to his profession and his patients.

Dr. G. A. Moses, while not claiming to be a run-mad specialist, was not disposed to do away with them or to join in the cry against them. It is true, as has been remarked, that the pendulum has perhaps swung to far, but it is only by a study of the extremes that we can arrive at a happy medium. He considered Dr. Boislinere's paper a most valuable one, but thought that it was rather too brief to deal fairly with so broad a subject. There was certainly a tendency with all of us to drop our extreme views and modify our practice as we grow in age and experience. In regard to chlorosis, he was not inclined to look upon it in all cases as a disease, but rather to regard it as a symptom, as a secondary result, often dependent upon some trouble which may be removed by appropriate local treatment, in conjunction, of course, with general remedies. American gynecologists, many of them at least, have paid especial attention to the surgical diseases of women, while on the other hand practitioners upon the continent of Europe, like Scanzoni, Courty and others, have laid more stress upon general therapeutics; such authors are growing more in favor daily.

Dr. Englemann would have been better pleased had Dr. Boisliniere gone more fully into details, and was sorry he did not borrow his illustrations from the field of gynecology rather than outside diseases, as in the case of iritis,, for example. He thought the allusion to Scanzoni by Dr. Moses was probably not a happy one, for somehow Scanzoni, to his personal knowledge, has had many unfortunate results. A good many of his patients, treated on the conservative plan, have gone away unrelieved, and been cured by others under operative interference. The gynecology of Europe is very different in many respects from the teaching even of such men as Thomas and Emmet, to say nothing of Sims. I find many cases yield to operation, which I had failed to relieve by other measures in the way of treatment.

Dr. G. A. Moses.—But you must remember, doctor, that Dr. Boisliniere excepted traumatic and many other purely surgical affections.

Dr. Englemann.—Of course there are many cases which can be well and even better managed without local treatment; this is especially true in the case of virgins.

Dr. Ford considered the position taken by Dr. Boisliniere the true one, and such as ought to be taken by all educated gynecologists. In all cases the proper course is to look at a malady in all of its bearings; the constitutional peculiarities of every patient should be fully inquired into. No one could be considered a properly trained physician who failed to take cognizance of all these points; we should always have an eye to the diathesis and other modifying conditions surrounding a case. While this is attempted, it must be admitted that it is often imperfectly done. There is too little deep thinking, together with a growing tendency to run after the purely practical, especially in surgery; hence specialism, to which we owe a good deal, has in many instances been pursued too far. No man should practice a specialty until he is competent through study and experience to properly trace cause and effect.

Dr. Papin said he was disposed to accept in many respects the pathological views of the late Dr. Linton; he believed many affections charged to reflex disturbances of the nervous system were in reality rather due to qualitative changes in the blood. Take, for example, a young girl with leucorrhea; she suffers from a drain which in the course of time brings on a series of disorders, due to poverty of the blood, such as dyspepsia, constipation, neuralgia, hepatic derangement, etc. In his opinion bad innervation less frequently influences the blood than bad blood influences the nerves. In many cases simple local application cuts off waste, and thus cures disease. Leucorrhea is often due simply to passive congestion, brought about by displacement of the uterus; in such cases the discharge acts as a relief to the turgescent vessels. The remedy in such a case is replacement of the uterus; a properly fitting pessary will often act like a charm.—*St. Louis Courier of Medicine.*

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, March 1, 1883.

FORDYCE BARKER, M.D., LL.D., President, in the chair.

INTRA-UTERINE INJECTIONS.

Dr. Laurence Johson related the history of a case which illustrated the possible dangers of intra-uterine injections with Chamberlain's tube. He had practiced the injections for about one week without any accident whatever, and the next time, introducing the tube with the utmost care, and throwing the current of water in with as near as possible the same force as had been previously used, he found, when the injection had been finished, that the water was tinged with blood, and some blood followed

withdrawal of the tube. A severe chill occurred within half an hour, the temperature rose to 107° F., the pulse to 160, and this condition continued for two or three hours and then subsided, and the patient had since progressed very favorably.

The President remarked that within the past few years he had had occasion to frequently use intra-uterine injections, and to express a word of caution to those whom he had met in consultation in regard to continuing the the use of intra-uterine injections in the treatment of septicemia and puerperal fever beyond a certain fixed point of time. It was well known that the uterine sinuses were closed ordinarily within three or four days after labor. It had occurred to him to see cases where the evidence had been conclusive to his mind that the introduction of the Chamberlain tube, a most excellent instrument to be used when intra-uterine injections are indicated, has been continued too long, and that after the sinuses have been blocked up by the formation of coagula or the contraction of the uterine tissues, some of the channels have apparently been opened, and the absorption of septic material has followed, as proven by serious reinfection. Furthermore, it has been noticed that after using intra-uterine injections for one or two days, when the tube is withdrawn it has been found to be covered more or less with little points of blood, and in some cases slight hemorrhage has followed, and in others profuse hemorrhage has occurred. Consequently he had frequently spoken concerning this possible danger in continuing the use of the tube for such a length of time that it becomes a source of traumatic injury to the internal surface of the uterus, and thus of infection.

Dr. Isaac E. Taylor then read a paper on

THE NATURAL FAULTY OR CONTRACTED PELVIS; WITH THE HISTORY OF A CASE OF LABOR, THE NON-DELIVERY OF THE CHILD, AND THE DEATH OF THE MOTHER, AFTER CRANIOTOMY AND CEPHALOTRIPSY.

The faulty pelves referred to embraced the equally contracted or the justo-minor, the infantile or the immature, and the male or the funnel-shaped. The patient, whose history was given, was twenty-nine years of age, healthy, whom he first saw in consultation with Drs. Wharton, E. A. Judson, Waterman, and others, on July 28th. At that time the pains were short and recurred at intervals of ten minutes; the os was dilated to about the size of a half-dollar, and the head occupied the left occipito-anterior position. Ergot produced only a very slight increase of pain. A third of a grain of morphine was then administered hypodermically, and the patient got some rest. On July 29th the os was found widely dilated, the head occupying the same position as before and resting at the brim. Forceps were applied, but no change could be effected in the position. Version was then attempted, but was unsuccessful. Craniotomy was then performed, and at that time the position of

the head was transverse, and at the superior strait with the brow presenting, and perforation was made on the right side. The cephalotribe was applied, the handles brought into position, and the brain more freely evacuated, and then traction was made for fifteen or twenty minutes without causing any advance. The instrument was then removed, and on examination it was found that the cranium had regained the form as before its application, and this Dr. Taylor believed to be not unusual. He then applied his long narrow-bladed forceps, and brought the head more securely into the pelvis. A right-angled blunt hook was inserted into the mouth of the child, and Meigs' long embryotomy forceps were applied, and the head brought into the inferior strait, and finally delivered after three hours' trial. The shoulders then offered an obstruction, and on examination he became convinced that the pelvis was naturally faulty, or equally contracted, and there was not sufficient space to permit any further manipulation by the hand. A right-angled blunt hook was introduced, and firm traction made, but no change in the position of the shoulders could be effected. During all this time the patient's general condition grew worse and worse, despite hypodermic injections of brandy and other measures, and she died undelivered after three and half hour's faithful trial.

This form of pelvis, the equally contracted, he believed, was much more frequently met with than is generally admitted, and that it should recieve as much consideration as those forms which depend upon certain general conditions, such as rachitis, malacosten, etc. The infantile or immature pelvis is explained by an arrest of growth due to some important impairment of the constitution. For the equally contracted and the male pelvis no such explanations could be received. In the male pelvis, or the funnel-shaped, or the Irish pelvis sometimes called, a condition of advanced ossification exists, and indicates a healthy constitution. Barnes regards the equally contracted pelvis as due to the fact that the person is small, but Dr. Taylor believed that it did not necessarily follow that a female of small stature should have a small pelvis. With the exception of some German writers, the subject of equally contracted pelvis had scarcely been mentioned. Valpeau had once said that he had yet to learn that such pelves ever offered an obstacle to successful parturition, but he soon afterward had an opportunity to become convinced to the contrary. The equally contracted pelvis sustains a normal relation to the size of the body, and the woman having it has the same general structure, and does not differ from health, either in stature or general condition. No positive information can be obtained in regard to the existence of this pelvis until labor has somewhat advanced. The position of the head may assist somewhat. It may be oblique at the superior strait; the occiput may dip at the commencement of labor, and it should do so, for flexion is absolutely and positively necessary. Should complete flexion not take place,

a brow presentation, or a face presentation, will usually occur. After delivery is completed some notion of the condition of the pelvis may be formed by the condition of the head, and the specimen presented gave an excellent illustration of this point. There was marked overlapping of the parietal bones, compression of the frontal bones, and a ball-like appearance of the cranium. Another means for determinning whether or not this pelvis is present is pelvimetry. Dr. Taylor did not place much confidence in the various methods of measuring the diameters of the pelvis, and believed that internal pelvimetry could be best accomplished by the introduction of the whole hand. If the hand moves freely in the cavity of the pelvis, the diameter must be more than three and three-fourth inches. In measuring the outlet of the pelvis Breisky's method was not valuable.

With reference to treatment, the use of the forceps was almost totally impracticable. Should craniotomy have been performed, version might succeed. Should the child's head rest in the cavity of the pelvis and the case be seen early, he would perform Cæsarian section; but if not, he would resort to either laparotomy or symphysiotomy, and he was inclined to regard symphysiotomy as the more acceptable operation.

Dr. E. B. Judson gave a *résumé* of the clinical history of the case reported by Dr. Taylor, described the successive steps of the craniotomy and the difficulty experienced in attempting to turn the child. A great danger in these cases, he thought, was liability to rupture of the uterus. The most interesting question, perhaps, was with reference to diagnosis; that is, whether there are any certain means upon which we may rely. He was inclined to think that internal pelvimetry might furnish something in this direction, and then referred to a method recommended by Carl Schroeder for obaining the diagonally conjugate diameter, as he had called it. It consisted in introducing two fingers, allowing the tip of the middle finger to rest upon the promontory of the sacrum, and then note upon the index finger the point at which it came in contact with the inner edge of the arch of the pubis. This diameter being obtained, it bears a certain relation to the other diameters, and perhaps in this way a proximate estimate might be formed with reference to the condition of the pelvis. With reference to external pelvimetry it did not seem to be of much service. He thought that some information might be obtained by resorting to abdominal palpation early.

Dr. E. L. Partridge, from a clinical standpoint, suggested that possibly the early appearance of menstruation might lead to the early ossification of the bones of the pelvis, and therefore might be of some assistance in forming an opinion with reference to its general condition. Again, it should be borne in mind, in endeavoring to arrive at an opinion as to whether a difficult first labor is likely to be succeeded by labors equally difficult and perhaps dangerous, that the first labor is frequently

severe, perhaps necessitates craniotomy, and yet subsequent labors are comparatively easy. This can be explained by the fact that ossification of the child's head is more complete in primiparæ than in multiparæ, and therefore the head less yielding. Practically he had found that the cephalotribe applied to the delivered head had facilitated delivery of the shoulders. He believed that the equally contracted pelvis should receive more consideration and study than simple cases of deformed pelvis from disease, because it probably occurred far more frequently, and it was very probable that craniotomy and cephalotripsy were performed more frequently in this class of cases than in any other.

Dr. H. J. Garrigues thought there was no doubt that diagnosis could be made during pregnancy. Of the external methods to be employed, he thought Baudelocque's instrument offered the most advantages. Internal pelvimetry was difficult to practice, but it might be assumed that if the finger could touch the promotory of the sacrum the pelvis was contracted. In cases in which operative interference was necessary he thought the following should be considered in the order mentioned: first, gastro-elytrotomy; second, Cæsarian section, not according to the old method but according to the methods recently described in monographs; third, Porro's operation; fourth, total extirpation of the uterus.

The President directed attention to one important practical point on which we are all liable to be consulted. It had already been alluded to by the author of the paper, namely, the external conformation, form and figure and size of the patient offered but slight indication of the condition of the pelvis. This is a point which should be constantly borne in mind. He had repeatedly had patients under five feet two inches in height, who had a perfectly normal pelvis, and had given birth to fine, healthy, and often large children. Again, those patients who have had antero-posterior and lateral curvature of the spine, perhaps also hip-joint disease, have experienced no difficulty whatever in the process of parturition. It some cases he had been able to form a pretty accurate estimate of the probable diameters of the pelvis, but not always, and oftentimes it was found quite impossible. He then referred to a case in which the woman had suffered from double curvature of the spine and also hip-joint disease in early life, and in whom he was unable to discover and deformity of the pelvis whatever, and she gave birth to a child weighing ten pounds and a half before her attending physician could reach her. The President also referred to a case of an exactly opposite character, in which a large, well-developed woman had so small a pelvis that it was with the utmost difficulty that she could be delivered of a child not very far advanced in development. Notwithstanding the proximate estimate which we might be able to make in certain cases concerning the diameters of the pelvis, he regarded it important to be extremely cautious with regard to promis-

ing favorable results during parturition even after having made a most careful and thorough examination.

In closing the discussion, Dr. Taylor briefly alluded to the equally contracted pelvis from a gynecological standpoint, and expresed the opinion that very many cases of uterine displacements were due to this peculiar condition of the pelvis rather than to disease of the uterus itself.—*The Medical Record.*

Editor's Table.

Woods Library of Standard Medical Authors.—We have received the initial volume of this series for the new year of 1883, twelve volumes are issued for the marvellous price of $15,00. The volumes are well printed, abundantly illustrated, and the style of binding this year very elegant. This year will be issued two volumes on *Gynecology*, one on *Electro-Therapeutics*, two on the *Microscope*, one on *Esophagus*, nasal cavities, etc., one on *Diseases of Women*, one on *Treatment of Women*, one on *Hereditary Syphilis*, two on *Legal Medicine*, (two previous volumes being embraced in the series of 1882) and finally a *Treatise on Veterinary Medicine*. We can scarcely realise in what way so much valuable reading matter can be obtained for so small an outlay of money.

The Risks of Medical Practice.—We have had occasion to refer in the past to the serious risks that physicians run, in the general practice of medicine, of being injured socially and professionally through the unfounded charges of bad, designing or hysterical women. Two recent cases cause us to again utter a word of warning.

In England, a young girl came to a physician, complaining of morning sickness, headache and total suppression of menses for five months. Suspecting pregnancy, he refused to give any emmenagogue medicine, as he was asked to do. An examination was made, with the girl's full consent, and the physician's suspicions were confirmed. The patient left, and the next thing the doctor heard was a summons for assault. Fortunately, he was able to produce the evidence of three visitors and three servants, who were all within ear-shot at the time, yet heard no outcry. The charge was at once dismissed. The other case occurred in Canada. A physician who had attended a woman for miscarriage, subsequently visited her (three weeks later) for some uterine trouble. Requesting her little boy (ten years old) to leave the room, he suggested a vaginal examination, which was made. He was subsequently charged with assault,

which charge was afterwards modified so that it seemed that the woman yielded to his persuasion. The husband wrote to the doctor, offering to compromise for $200. The doctor refused, and determined to stand trial. The little boy was coached to testify that, going into the back room, he saw, through an open door, the doctor leaning over his mother, and heard her say, "What will my husband say?" In rebuttal, it was proved that this door had not been open for months, and that both man and wife were disreputable and unworthy of belief. The doctor was triumphantly acquitted.

Happily, such cases are rare in our country, but they are liable to happen at any time, to any physician; and, even though acquittal results, yet such a charge leaves behind it a cloud well calculated to prove a loadstone on the reputation and prosperity of the physician.

To avoid the possibility of such a calamity, it should be made an absolute rule, admitting of no exceptions, that examinations of women should never be made save in the presence of reputable witnesses; and further, the leaders of the profession in a district should unite to prosecute, to the fullest extent of the law, any one who prefers such serious charges when they have been proven to be false and groundless.

We congratulate the Canadian doctor on his manliness in fighting this charge.—*Medical and Surgical Reporter.*

Inheritance of Cancer.—In the course of a paper on the Local Origin of Malignant Growths, read in the Section of Pathology at the last annual meeting of the British Medical Association, Mr. Jonathan Hutchinson observed: "It is needful to say a few words as to the Inheritance of cancer in its bearings upon the doctrine of its local origin, since an adverse argument has been founded upon it. It has been urged with much plausibility, that a disease which is capable of inheritance must be a constitutional one. No doubt, to some extent, this is true; but the argument must not be pushed beyond its legitimate scope. The laws of inheritance, as with property, so with disease, concern convection, and not origin or production. The inheritance of a fortune is a very different thing from its acquisition, and gives no clue as to how that may have been accomplished. The causes of cancer, as we meet with it in practice, may, perhaps, be usefully classed as three, senility of tissue, local irritation, and inheritance. Of these, only the two can rank as true causes; the latter, although practically of great importance, is only a mode of perpetuation of that which the other two have originated. Senility gives proclivity, local irritation excites, and subsequently hereditary transmission may perpetuate. The facts, as regards chimney-sweeps' cancer, gives perhaps the illustration of what I mean. Before this malady was practically suppressed by Act of Parliament, I believe as it often did, in a family, proneness to suffer from soot-warts and for soot-warts to

degenerate into cancer, increased in successive generations. Grandsons and great-grandsons were attacked at earlier ages, and with much greater frequency, than those who were new to the trade. Here, then, we observe the liability to a form of cancer, produced in the first instance by a local cause, perpetuated and intensified by hereditary transmission. We witness the genesis of cancer, and see the shares taken by local irritation and inheritance, and how entirely secondary the latter is as regards the former. If we ask what it is which is inherited in the case of the transmission of cancer, probably the nearest approach to an answer which can be given will be to say that it is a peculiarity in cell-structure generally; not germs, not a blood-malady, but a special type of cell organisation, permitting with greater ease than in other persons, the injurious influence of local causes, Even in the sweep, whose forefathers have suffered from soot cancer, the transmitted tendency still waits for the exciting cause; and the disease occurs, not in internal and, therefore, protected parts, but on the same part as it did in his great-grandfather, and under the direct influence of exactly the same cause. Not that I would for one moment doubt that, in some instances, the inherited proclivity may be so strong, that it does not wait for the help of any exciting causes, but manifests its power in the production of a cancer which may be considered spontaneous. It is probable in this way that we ought to explain almost all cases of cancer occurring in very early life; and it may be the fact that, in a few of these, something more definite than mere tissue proclivity may be transmitted, possibly even germinal matter, especially in those cases in which the parent was the subject of the malady. Thus, then, although I fully admit that in the examination of our patients we must make large allowance for the influence of inheritance, I wholly deny that we can allow it rank as a true cause of cancer."—*British Medical Journal.*

Uterine Dyspepsia.—In an article upon the *Prager Medicinische Wochenschrift*, December 20, 1882, Dr. E. H. Kisch remarks upon the relationship existing in health between the stomach and the uterus. He states that while normally the reaction of the stomach becomes neutral in five to seven hours after a meal, during menstruation it remains constantly acid. Not all affections of the female sexual organs give rise to dyspepsia, but only those of the uterus itself, and of these may be excluded all superficial erosions and affections of the mucous membrane, thus leaving as causes only the structural changes of the organ, versions, flexions, subinvolutions, deep follicular and cancerous ulcerations, and similar conditions. The most frequent cause of digestive disturbance he finds to be retroflexion. The symptoms vary much in intensity, sometimes, however, they assume a most threatening severity. The appetite is capricious, the tongue is but slightly coated. There is often pain in the

epigastrium, with sour eructations and heartburn. Sometimes there is vomiting after each meal, together with constipation and flatulence.

Sympathetic disturbances are common, such as palpitation of the heart, neuralgia, melancholia, etc. The affection is to be distinguished from gastric catarrh, ulcer of the stomach, and simple nervous dyspepsia. This to be determined by attention to the symptoms peculiar to each of these conditions, but especially, and sometimes only, by the results of treatment. With the improvement in the affection of the uterus the dyspeptic symptoms subside. Hence all curative efforts are to be directed especially against the abnormal condition of the uterus. Certain mineral waters are often of great value, especially those eontaining sulphate of sodium. The author concludes by urging the necessity of a uterine examination in all case of obstinate dyspepsia occurring in females.—*Medical Record.*

The Weir-Mitchell Treatment.—Every physician who knows anything at all, knows very well that Dr. S. Weir-Mitchell, of this city, has established upon a rational foundation his method of treatment of certain nervous disorders, by means of forced feeding and forced utilization of the food so ingested.

Dr. Playfair, of London, has been using the same methods now for some eighteen months, and his successes fully coincide with Dr. Mitchell's.

The case best suited for systematic Weir-Mitchell treatment is the worn and wasted, often bedridden woman, who has broken down, either from some sudden shock, such as grief, or money losses, or excessive mental or bodily strain, beginning with simple debility more and more yielded to, until at last all power of effort is lost. Coincident with this is the total loss of appetitite, the profound anæmia, and the consequent wasting of the tissues.

Then follows the graver forms of hysterical disease, such as paresis, or paralysis, vomiting, disorder of motion, hystero-epilepsy, and many others, which constitute the despair of the physician.

The principal elements in the systematic management of these cases are:

1. The removal of the patient from unhealthy home influences, and the placing her at absolute rest.

2. The production of muscular waste, and the consequent possibility of assimilating food, by what have been called "mechanical tonics," viz., prolonged movement and massage of the muscles by a trained shampooer, and muscular contractions produced by electricity.

3. Supplying the waste so produced by regular and excessive feeding, so that the whole system, and the nervous system in particular, shall be nourished in spite of the patient.

Since one the chief elements in this treatment is the removal of the patient to a hospital, thus isolating her from the morbid influence of well-meaning but injurious commiseration of anxious friends and relatives, it is evident that its application is restricted to cities, and cannot be well carried out in country districts, where no such homes or hospital exist.

The experience of these two eminent gentlemen is highly satisfactory, and it behooves us all to give great heed to these evidently valuable therapeutic measures.—*Medical and Surgical Reporter.*

Extraordinary Customs of the Aborigines of Central Australia.—Dr. J. M. Creed contributed an essay on the above subject to the *Australasian Medical Gazette* as follows:

At various times, and from various absolutely trustworthy sources particulars of the following singular custom have come to my knowledge. Its singularity being extreme, and the fact of such a custom (really the most perfect form of "Malthusianism" practicable) being thought of and carried on probably for ages by a race generally considered so low in the scale of intelligence, renders its publication desirable, and as it is surgical in its nature, the *Gazette* appears to be the best medium for the purpose. Throughout the whole of the interior of the continent, from the eastern boundary of the watershed of the Georgina river on the east to nearly the settled districts of Western Australia on the west, and from the coast range on the north to Cooper's Creek watershed on the south, the men have an artificial opening in the inferior wall of the urethra, just anterior to the scrotum; in some tribes this opening is only from one inch to one inch and a half long; in others the whole of the posterior wall is removed, so as to absolutely destroy the canal from the scrotum to the base of the glans penis. In copulation the semen is, of course, emitted at the inferior end of this opening, and external to the vagina of the female, so that impregnation by sexual intercourse with the men so operated on is impossible, and this effect seems to be the desired end for which the operation is performed. From inquiries made by my informants (pioneer settlers) of partially civilized blacks who themselves had been operated on, it seems that the period of life at which this custom is carried out differs in various districts; in some it is done to the boys about the age of puberty, in others to the men at a more advanced period of life. Hume, when he returned to Sydney in 1873, in giving an account of his wanderings amongst various, at that time unknown tribes of natives, in search of the relics of the traveler Leichhardt, gave the first account of this custom, which came to my ears. He said that tribal laws as to the possession and occupation of hunting country, good places for fishing, etc., are so strict and so rigidly carried out, that no tribe, however much in want of food, dare go beyond the limits of its own territory to obtain it in that of another; and that, consequently, it had become necessary, in some

way, to check the ordinary increase of population, so as to keep the numbers of the tribe always about the same, and equal to the food supply of their district. To do this he said every blackfellow was allowed to procreate two children, and that then by the laws of the tribe he was, by operation, rendered for the future, sterile, though not impotent. He said also that the (gins) women after producing the same number of children were, by some operation, rendered sterile for the future.

Another gentleman, an ex-Minister of the Crown in a neighboring colony, who, when exploring, lately examined many of these blacks, gives me the same account of them as Hume, and in addition was able to furnish me with some particulars as to the operation performed on the women, which was told him by members of the tribe. To render the women sterile they insert a stick, and sometimes in addition, hair into the vagina, and presumably into the uterus; this, the blacks say, produces the desired effect. Probably the way it does so is by setting up adhesive inflammation in the fallopian tubes, and thus causing closure of their canal, rendering passage of the ovum impossible. Either at the same time at which the stick is inserted into the uterus or afterwards, I have not been able to ascertain with accuracy which, the woman when lying on the ground has her abdomen kept continually covered with very hot sand, heated by fire, and put and kept on as hot as it is bearable. I fancy that could we know positively the period at which this is done, we should find it to be afterwards, and that it is the treatment adopted to subdue the peritoneal inflammation which must be generally set up, as we in civilized communities use hot fomentations for the same purpose. The mortality amongst the women is said to be one in six.

A third friend (whom I have known since boyhood, and whose truthfulness is undoubted), tells me that in September, 1882, at a place in latitude 22° south, and longitude 137° east of Greenwich, an exploring party under his command came across and examined a party of natives about 50 in number, comprising men, women, and children. The men were all operated on, and the women, with the exception of the younger ones, had the nipples of their breasts cut off. He engaged for work on his station three of the boys who were about the age of puberty, and who had been operated on within two or three days. One of these boys had been in the employ of whites before, but had come back to his friends, and could speak English fairly. He told my informant that the boys were as a rule operated on at that age, and that they were very proud of it, but that some members of the tribe were left unoperated on for purpose of procreating children to continue the race, and that these were very "saucy fellows." The rite is, at all events amongst this tribe, performed with considerable ceremony, the boys pointing out an enclosure of some thirty feet square, with thick walls of brushwood some six feet high, near a running stream, as the scene of operation, and as being always erected

for the purpose. Another settler who had every opportunity for knowing, tells me he learnt that these non-sterile men lived in a district by themselves, and that the women, when their impregnation was desirable, were sent to them for the purpose.

The amputation of the nipple of the women I take it, is also done with a view to check increase of population. Though it would not prevent the child being produced, yet amongst savage races the absence of the capacity of suckling the child must of necessity cause its death, for the mother would be unable to feed it, having no artificial substitute for her milk or means of catching the milk from her nippleless breast to feed the child.

I have given the facts as they have been related to me, and they are supported by such undeniable testimony that my readers may be certain of their truthfulness. Perhaps, as to the tribal rules under which this operation is done, we may obtain some further information as to the number of children allowed to be procreated by the men in those tribes where they are all operated on in later life. For it is apparent that were every man and woman allowed to have two children only before they were rendered sterile, that from the deaths which would occur amongst them from accident and disease, the tribe would gradually become extinct. I hope to get further information on these interesting customs, to obtain which I am sending a series of questions to all the settlers in the districts where these tribes live, asking accurate and careful answers; these, when obtained, I will publish. I may say that natives with their urethras perforated are found so near the settled districts of Western Australia as to have had some of their number incarcerated on Rottnest Island, the penal settlement of that colony for aboriginal offenders. The custom is also mentioned in Sir John Lubbock's "Pre-historic Times," as one common amongst the aboriginals at Port Lincoln, S. A.

Dr. Robertson, a gentleman who is traveling throughout the world on business relating to mines, and who has seen and examined some of the Australian instances, tells me he has examined similar cases in Borneo, where it is a custom of the "Kyan" tribe.

The late Mr. E. Hill also found it to be a custom of one of the Islands he visited in the Pacific, but unfortunately I am unable to ascertain which one. It is an interesting speculation as to how this curious custom has arisen. I think that the most probable explanation is, that at some remote period an individual was born with that rare malformation of the urethra "Hypospadias," and that some intelligent man amongst the tribe realized the effect it had in rendering the victim of it sterile, and the possibility of producing the same thing by operation. It is likely that prior to this, the numbers were kept down by simple infanticide.

All the individuals examined were found, in addition, to have been cir-

cumcised. The instrument used for both operations is a chip of flint formed into a knife.

On Rape During Hypnotic Sleep.—In the winter of 1880–81 a "magnetizer" visited Neuchatel, and by his public exhibitions of his powers created a "magnetic" epidemic, especially among the young people. One of the results of this excitement became the subject of a judicial investigation. A young woman applied, through her pastor, for accommodations at a lying-in hospital for her approaching confinement. She declared that she was eight months pregnant, and that her pregnancy dated from one evening when she was alone with a young man who had the power of "magnetizing" her, and who had violated her after he had put her to sleep. The case came to the notice of the district officers of justice, and Dr. Ladame was required to answer, as an expert, the following questions:—

(1.) Is the statement of Maria F. to be regarded as trustworthy in its general features?

(2.) Did the sexual connection take place under the conditions described by her and without her ability to account for it?

(3.) Was her will wholly paralyzed, and could she not have resisted her seducer?

(4.) Is conception possible when the woman is in a state of absolute insensibility?

Dr. Ladame, in his reply to these judicial inquiries, first calls attention to the novelty of the subject in its medico-legal relations. He states that only four authentic cases of the kind in question are on record in medical literature. Liman, professor of legal medicine at Berlin, declares that in an experience of twenty years as a medical jurist he has not seen a single instance of magnetic sleep, and that he has never been called upon to pronounce upon a criminal case relating to magnetism. Hofman, of Vienna, likewise asserts that he does not know a single case recorded in German literature of rape during hypnotic sleep.

In France the first case published occurred in 1858. MM. Coste and Broquier, the experts in this case, summarized their conclusions as follows: "We think that it is possible that a young woman should be deflowered and impregnated against her will, her powers of volition being overcome at the time by magnetism." The experts in this affair remarked that "if a young woman under the influence of magnetic sleep is insensible to all sorts of pain it seems reasonable to admit that she can undergo the act of sexual intercourse without any voluntary participation in it, without, indeed, any knowledge of it, and consequently she could not forcibly resist it," Devergia agreed, in consultation, with these conclusions, although he called attention to the great ease with which magnetic

sleep could be simulated under such circumstances. Tardieu gave a qualified assent to these opinions, but remarked particularly upon the possibility of deception.

In a second case (1865) the experts expressed themselves in nearly the same terms as did those in the affair just related. A third case was published by Tardieu in 1878, and a fourth, and the latest on record (1879), was under the investigation of Brouardel, professor of legal medicine at Paris, who arrived at results very nearly like those in the preceding instances, namely, that a girl may be violated during magnetic sleep.

After a full and interesting discussion of the various topics relating to the case under his observation,—the phenomena of hypnotism, the degrees to which the will of the victim may be overcome, the possibility of sexual intercourse in this condition without the consent of the woman, the means of distinguishing genuine from fradulent hypnotism, the possibility of conception when the woman is unconscious from any cause, the author formulates as follows his answers to the questions propounded to him:—

(1.) We are compelled to admit that Maria F. could be violated by Louis V. after being magnetized by him. In this state she could not resist the intercourse, and she has not preserved any remembrance of what transpired, or a confused recollection of a part only of the occurrence.

(2.) Conception has frequently followed rape, and the date of the confinement of this girl shows that the fecundation coincided with the time of the alleged rape.

(3.) In the absence of a medico-legal investigation immediately after the occurrences in which the two parties were involved on the occasion in question, it is impossible to affirm positively that the woman was really put to sleep by magnetic influence with criminal intent and ravished while in that condition.

(4.) It would doubtless be easy to obtain a detailed account of that scene by magnetizing Maria F., but the experiment might be exposed to error, because in hypnotic sleep one can voluntarily or involuntarily suggest to the person sleeping dreams and hallucinations of which she describes the details with astonishing precision.

(5.) Although important information might be gained by this renewed magnetizing of the woman, it would not in any case serve as sufficient evidence upon which to base a judicial conclusion.—*Boston Medical and Surgical Journal.*

Infantile Ascites.—Professor Simpson exhibited to the Obstetrical Society of Edinburgh (*Medical Press*, January 17, 1883,) a case of a child which died immediately after birth from ascites of the peritoneum. There was fluid in the scrotum, showing a direct connection with the peritoneum.

Foreign Gleanings.

TRANSLATIONS FROM THE FRENCH AND GERMAN.

[Prepared for the OBSTETRIC GAZETTE.]

TRISMUS ET TETANUS NEONATORUM.—This child is eleven days old and yesterday for the first time showed that it was ill by refusing the breast. Its weight has decreased considerably, the skin is a pale yellow, the muscles feel stiff, the extremities are bent, the fingers clinched, the head is fixed backwards, the forehead is wrinkled, the alæ nasi dilated, the lips parting half opened and pointed, reminding one of a fishes' mouth, the jaws so firmly closed as to make opening the mouth for an examination impossible. The face around the mouth is bluish, the features have a mask-like immovability, the breathing is painful and irregular, the thorax anteriorly pretty well thrown out and showing in the back a kyphotic curve. The umbilicus is slightly ulcerated, the skin reddened around it.

We have here a tonic muscular rididity to deal with. The heart is normal, the percussion-note a trifle less sonorous, the temperature is slightly increased. We get two or three cases yearly in two thousand five hundred births. Death is the termination in most cases. The child cannot nurse, the respiratory muscles are crippled in their work, and the temperature is generally high, increasing as in adults towards death and even beyond it. Pathological anatomy does little for us. The hyperemia of the brain, spinal cord and their meninges, the fullness of the heart and venous trunks, and the œdema or hyperemia of the lungs, which the autopsy shows are secondary. The appearances resemble those in death from suffocation or strychnine poisoning. The etiology is yet quite obscure. In most cases there exists trouble at the umbilicus, superficial ulceration or suppurative inflammation of the arteries or veins. The case preceding this had an umbilical hernia. It would be difficult to prove that this disease originates in a septic infection, though some things point in that direction. Soltmann's experiments with animals gave negative results, and does not disprove the fact that it may be of septic origin. It is certain that it is oftener observed in certain unfavorable hygienic circumstances, and under such circumstances becomes epidemic in lying-in and foundling establishments. And that when these conditions were bettered the disease disappeared. Unusual thermic irritation causes it, as putting infants in too hot water for their first bath. It is especially frequent in the torrid zones, and among negroes who are unclean and care-

less in dressing the navel. Carefully supervised inhalations of chloroform may be tried, as treatment, hourly. Monti has used calabar successfully—others recommend musk in drop doses. The autopsy of this child a few days later showed arteritis umbicolis, hyperæmia of brain and spinal cord and œdema of the lungs.—*Dr. Eppstein's Clinic, Prague.* M. STANTON.

MASTITIS.—This infant is twelve days old, well developed and nourished, and but for an affection of the right breast, perfectly healthy. The right breast is swelled, reddened, the nipple sunken, and palpation gives distinct fluctuation. We have an inflammation of the glandular tissue, a condition not uncommon in children of this age. The breasts of new born children, boys as well as girls, resemble, in some particulars, those of a lying-in woman, they swell and contain a milk-like secretion and feel knotty. The secretion under the microscope bears out the resemblance, although the corpuscles are not as abundant as in woman's milk.

Chemical analysis also shows the similarity of the two fluids. It seems to sustain some relation to that peeling off process that takes place not only in the skin and mucous membranes, but in the salivary, oil, sweat, and other glands. A section of the milk gland at that time shows its ducts widened and filled with epithelial debris. This clinical observation may have some physiological significance—the desquamation and disintegration of the glandular epithelium may relate in some way to the origin of the milk. The quantity of milk is sometimes so great that an incision causes it to flow free from the products of inflammation. In some cases there is a circumscribed phlegmonous abscess, entirely independent of the gland, again part or the entire glandular tissue may be involved. The pus can break into a large duct and stream from the nipple, or one lobe after the other is affected and necessitates several incisions. In exceptionally unfavorable cases the abscess may extend over the thorax open in an intercostal space and occasion a fatal pleuritis. Mastitis is either primary or secondary. It attacks healthy children as well as those who are suffering from other suppurative processes or other diseases. It is often the first symptom of pyæmia. Cover the glands with cotton—in making incisions, especially with girls, cut radiating from the nipple.—*Ibid.* M. S.

PARAMETRITIS POSTERIOR.—Our patient, this morning, is thirty-six years old and very hysterical. Her illness dates three years back, after her first delivery, shortly after which she suffered from fever with pelvic pains. During her examination single groups of muscles besides those of the upper extremities are attached by clonic convulsions. The uterus is ante-verted, a small polypus hangs from the os. Moving the cervix to the left causes intense pain, as does pushing it up, the same manipulations on the other side cause no distress. We find below and to the right

a thin painful cord passing from the cervix towards the rectum. This is the shrunken and resistant ligamentum uterinum dextrum, and the result of an infiltration of the areolar tissue after parametritis. The excessive pain is explained by the fact that the plexus cervix uteri is situated here. This sensitive cord may be felt better through the rectum. According to Schultze this trouble is always accompanied by anteversus uteri, because these ligaments shrink and fix the neck backwards. If both sides are affected defecation is difficult and coitus impossible. This affection is so rare and so difficult of diagnosis, that the pain is regarded as hysterical, and often the whole thing simulated. Before it was described by Schultze, I saw a case of it in a fifteen-year-old girl in Berne. She passed through an attack of pelvic inflammation, and six weeks after came to me. She carried heavy loads and might have ruptured these ligaments, then there was an extravasation, a peritonitis and a shrinking of the ligaments. Our patient is too old to be capable of resorption. We must prevent as far as possible the movements of the bowels and uterus in order to alleviate the suffering. Freund considers its origin chronic, but I find it resulting mostly from acute processes, traumatic puerperal; post abortion, etc. Schultze later agrees with Freund in its chronic origin, as it may originate in a married woman, there being a want of proportion in the genitalia of the couple, and it cannot be denied that it sometimes exists in sterile women with short vaginæ, in whom the ligaments may be ruptured. But this is extremely rare. The same circumstances may occur in obstinate constipation. The prognosis is quite unfavorable. Resorption can seldom be induced, the ligaments cannot be cut. Soft elastic cotton tampons may be used to moderate movements in emptying the bladder and rectum and in walking. Alleviating symptoms as they are present in different cases. — *Ibid.* M. S.

Abstracts and Selections.

II.—GYNECIC.

Reposition of Complete Inversion of Uterus After Five Years' Duration.— Dr. Arthur W. Edis writes as follows to the *British Medical Journal:*

Mrs. D., aged 29, married at 21, mother of two children, widow, had suffered from more or less continuous uterine hemorrhage since her last confinement in December 1877. At times, the loss amounted almost to flooding, especially at the menstrual periods, when it would last for nearly a fortnight. Her general health was fairly good, and seemed to be less

influenced by the constant drain upon her system than might have been anticipated. She suffered from no unusual pain beyond a sense of dragging in the loins, and pain extending up to the back of her head, worse on walking or standing. Attempts had been made to prevent this "falling of the womb" by the insertion of a ring-pessary, as also to reduce the displacement by means of air-ball pessaries, the patient on one occasion, being treated for two weeks consecutively, remaining in bed and following out strictly the injunctions given. She was seen in the early part of August 1882 by Dr. B. Arcedeckne Duncan, who diagnosed the displacement, and asked me to see her in consultation with him.

On examination *per vaginam*, a soft, velvety, globular mass, sensitive to the touch, and bleeding readily, was found occupying two-thirds of the vaginia; it was adherent by a surface about the size of a six-penny-piece to the posterior vaginal wall. The uterine sound could only be felt encircling the pedicle of the tumor. On conjoined manipulation, the fundus could not be detected in its usual position behind the pubes, but only a cup-shaped depression on deep pressure. The nature of the case was so evident, that it was considered unnecessary to examine *per rectum*, or to pass a sound into the bladder to confirm the diagnosis. As the menstrual period was just pending, it was arranged to wait until this was over before commencing efforts to reduce the misplaced organ.

On August 22nd, at 9:30 a. m., the patient having been kept in bed for a few days and the bowels carefully regulated, Aveling's uterine repositor was carefully adjusted. The adhesion of the fundus uteri to the posterior vaginal wall was torn through with the finger, scarcely any hemorrhage resulting. A morphia suppository was inserted *per anum*, to allay any pain likely to be caused by the pressure of the instrument.

The patient was seen at intervals of about three hours during the day, and the amount of pressure carefully regulated. Searcely any inconvenience was experienced, the pulse and temperature remaining normal. The urine was drawn off with a catheter. At 10 p. m. the pulse was 72, the temperature 99°, the patient very comfortable.

August 23rd, 9:30, a. m. The patient slept fairly well with the aid of a morphia suppository; pulse 72, temperature 99°. The bulk of the stem was found to be buried within the rim of the cervix, and was, with some little difficulty, removed. The vagina was syringed with Condy's fluid diluted, and the stem readjusted. 9:30 p. m. pulse and temperature normal. The patient felt very comfortable; stem *in situ*.

August 24th, 9:30 a. m. Forty-eight hours from commencement of efforts at reposition; pulse 96, temperature 99°. The patient had a comfortable night. The bulk of the instrument was completely within the uterus, the stem firmly gripped by the now contracted os uteri. After washing out the vagina, on examination, the partly inverted fundus could just be felt within the uterus. It being that possibly the concavity of the

bulb of the repositor prevented complete reinversion, a small India-rubber ball, about one inch in diameter was passed into the uterus, and the repositor reapplied. 9:30 p. m. On examination, the bulb of the repositor was found to be external to the os uteri, evidently not exerting pressure upon the fundus. The ball was therefore removed, the vagina washed out, and the bulb of the repositor readjusted on the still partially inverted fundus uteri. Pulse 96, temperature 100°. A morphia suppository (*Gr.* 1-6th) was inserted *per anum*.

August 25th, 9:30 a. m. On examination, the bulb of the repositor was found to be completely imbedded in the cavity of the uterus. The apparatus was removed, and the vagina washed out as before; pulse 96, temperature 99°. On passing the finger within the cervix, the fundus uteri could no longer be detected. The patient was kept quiet in bed, and an enema administered. 4 p. m. Dr. Duncan and myself examined most carefully, but failed to detect any remains of inversion. The uterine sound passed upwards and forwards three and a half inches, and the fundus could be felt in its normal position by conjoined manipulation. A mixture of ergot and cinchona was prescribed, and the patient kept in the recumbent position for nearly a week subsequently. She convalesced rapidly, and, when heard of some months afterwards, reported herself as "quite well, the periods regular, not profuse nor painful." She has since married again, and remains perfectly well.

REMARKS.—The reinversion was completed within seventy-two hours; practically, it was all but accomplished in forty-eight hours. During the last twenty-four hours, owing to the tenderness produced, the elastic pressure was lessened. One disadvantage of the bulb being conical in shape is that, after the process of reinversion is well advanced, the cervix contracts around the stem of the bulb, rendering the extraction of the latter difficult. If the bulb of the instrument were altered in shape, so as to be of an uniform thickness for at least four inches, only slightly conical, so as to prevent the os uteri contracting around it, its withdrawal would be greatly facilitated.

Laparo-colotomy for Removal of a Foreign Body.—At the last German Surgical Congress UHDE (*Beilage z. Cbl. f. Chir.*, No. 29, 1882) showed a wooden tool he had removed from the left colon of a man, aged 25, by laparo-colotomy. The tool was one used for sewing sacks, and measured nine and one-quarter inches in length, with a circumference at its thicker end of three and one-half inches. The patient, an inmate of a house of correction, had pushed this into his rectum on the 1st of June, 1882, and left it there. On the 25th of June a sudden movement of the body was followed by abdominal pain, and he found that the tool after that was not so easily felt from the outside of the abdomen as it had previously been. In July he suffered from feverishness, diarrhœa with bloody

evacuations, tenesmus, and difficulty of micturition. In October there were rigors, with severe pain in the left hip and thigh. The pain increased so much that on 6th of April, 1882, he came to the hospital at Braunschweig for relief. At that time the foreign body could be felt through the abdominal parietes to the inner side of the left antr. supr. spine of the ilium. On the next day an unsuccessful attempt was made to reach it by introducing the hand and part of the forearm into the rectum. On the 13th of April an incision was made in the left linea semilunaris, through which the foreign body was left within the descending colon, jammed between the last rib and the sacrum so firmly that the colon was only brought to the wound by considerable traction. The piece of wood was removed through an incision in the gut nearly one and one-half inches in length, and this incision was closed with silk sutures, The operation was performed antiseptically, and, in spite of considerable vomiting and hiccough during and after the operation, the patient made a good recovery.

Similar operations, both successful, were performed by Reali in 1868, and by Studsgard in 1878. In the former case the foreign body had been in the bowel for nine days, in the latter for twenty-four hours. In the present case it had been there for three hundred and seventeen days. —*Glasgow Med. Journ.*, March, 1883.—*Medical Progress.*

Bent Tibiæ in Children.—Dr. C. Steele, in *Brit. Med. Jour.*, Dec. 1882, p. 1293, in a short paper, speaks of those cases of bent tibiæ in children where the inner surface presents a curve outwards and backwards, and in so doing gives a curve to the ankle, turning the toes inwards. Dr. Steele remarks that this condition is generally observed in fine children soon after they begin to walk, and he holds that the deformity is congenital, due to the position which the child's legs and feet occupy *in utero*, especially if the child be a large one and the liquor amnii small in quantity. The treatment recommended is the early use of an elastic power acting on the bone affected, leaving free the knee and ankle joints by means of a light instrument which can be worn both day and night.

Gossip.

AMERICAN MEDICAL ASSOCIATION.—The Thirty-fourth Annual Session will be held in Cleveland, Ohio, on Tuesday, Wednesday, Thursday, and Friday, June 5, 6, 7, 8, 1883, commencing on Tuesday, at 11 A.M.

"The delegates shall receive their appointment from such permanently organized Medical Societies as are recognized by *representation in their respective State Societies*,

and from the Medical Department of the Army and Navy, and the Marine Hospital Service of the United States.

"Each State, County, and District Medical Society entitled to representation shall have the privilege of sending to the Association one delegate for every ten of its regular resident members, and one for every additional fraction of more than half that number: *Provided:* however, that the number of delegates for any particular State, territory, city or town shall not exceed the ratio of one in ten of the resident physicians who may have signed the Code of Ethics of the Association."

Secretaries of Medical Societies as above designated are earnestly requested to forward, *at once*, lists of their delegates.

Also, that the Permanent Secretary may be enabled to erase from the roll the names of those who have forfeited their membership, the Secretaries *are, by special resolution*, requested to send him annually a corrected list of the membership of their respective societies.

SECTIONS.

"The Chairman of the several Sections shall prepare and read, in the general sessions of the Association, papers on the advances and discoveries of the past year in the branches of science included in their respective Sections. * * * "—*By-Laws*, Art. II, Sect. 4.

Practice of Medicine, Materia Medica, and Physiology:
Dr. J. H. Hollister, Chicago, Ill., *Chairman.*
Dr. J. G. Lee, Philadelphia, Pa., *Secretary.*
Obstetrics and Diseases of Women and Children:
Dr. J. K. Bartlett, Milwaukee, Wis., *Chairman.*
Dr. G. A. Moses, St. Louis, Mo., *Secretary.*
Surgery and Anatomy:
Dr. W. F. Peck, Davenport, Iowa, *Chairman.*
Dr. P. F. Eve. Nashville, Tenn., *Secretary.*
State Medicine:
Dr. Foster Pratt, Kalamazoo, Mich., *Chairman.*
Dr. T. L. Neal, Dayton, O., *Secretary.*
Opthalmology, Otology, and Laryngology:
Dr. A. W. Calhoun, Atlanta, Ga., *Chairman.*
Dr. Carl Seiler, Philadelphia, Pa., *Secretary.*
Diseases of Children:
Dr. R. F. Blount, Wabash, Ind., *Chairman.*
Dr. J. H. Sears, Waco, Texas, *Secretary.*
Oral and Dental Surgery:
Dr. D. H. Goodwillie, New York City, *Chairman.*
Dr. T. W. Brophy, Chicago, Ill., *Secretary*

A member desiring to read a paper before any Section should forward the paper, or its *title* and *length* (not to exceed twenty minutes in reading), to the Chairman of the Comittee of Arrangements at least one month before the meeting.—*By-Laws.*

Committee of Arrangements.—Dr. X. C. Scott, 393 Euclid Avenue, Cleveland, O., *Chairman.*

Amendments to the Constitution:

Offered by Dr. N. S. Smith, Dakota:

"To provide for the admission to membership of two delegates from the Medical Bureau of the United States Indian Service, to be nominated by the Surgeon in-Chief of that Bureau, and approved by the Secretary of the Interior."

Offered by Dr. J. M. Toner, D.C. :

"That the office of Permanent Secretary be vacated, and that the Nominating Committee hereafter annually nominate a Secretary without compensation."

Offered by Dr. F. Pratt, Mich. :

"That the law requiring the nominations of officers to be made *from those members present at the annual meeting*, shall apply only to the President, Vice-Presidents, Chairmen and Secretaries of Sections, the Assistant Secretary, the Chairman of the Committee of Arrangements, and the Judicial Council."

Offered by Dr. J. M. Keller, Ark. :

"To permit the holding of the annual meeting as late as the first Tuesday of September, if desirable."

Offered by Dr. J. H. Sears, Ark. :

"That the Chairman and Secretary of each Section may add any number of earnest workers to their Sections, in addition to those named by the Nominating Committes, and that the Librarian be made a permanent officer."

Amendment to the By-Laws—

Offered by Dr. J. W. Smith, Iowa. Art. II, Sect. 8. Permanent Members: strike out the words "but without the right of voting."

Philadelphia, 1400 Pine St.,
S. W. Cor. Broad.

WM. B. ATKINSON, M.D.,
Permanent Secretary.

DR. RICHARD MEADE, who became so famous in the seventeenth century, made himself remarkable among other things as the doctor who fought a duel. It was with Woodward, who had not only attacked him in his writings but had insulted him in public. Matters came to a climax one day when they were leaving Gresham College, and Meade's patience gave way. He drew and called upon Woodward to defend himself. It is related that Meade succeeded in disarming Woodward and telling him to beg for his life. "Never, till I am your patient," was the reply.—*Medical Record.*

DR. R. S. STEVENS, of Pittsburg, has returned from an extended European trip of eighteen months. He spent two and a half months with Billroth; three and a half with Schroeder; three months with Keith; two and a half months with Tait; three months with the Samaritan Hospital, Kœberly, Pean and Nussbaum. He saw about 112 intra abdominal operations and about 1000 ordinary gynecological ones. About this time the doctor opens a Private Hospital, and will largely devote himself to abdominal surgery.

AN ENGLISH TRIBUTE TO OLIVER WENDELL HOLMES.—*London Punch* thus felicitously rhymes on the resignation of Dr. Holmes from the chair of anatomy in Harvard :

Your health, dear "Autocrat!" All England owns
Your instrument's the lyre, and *not* "the Bones."
Yet hear our wishes—trust us they're not cold ones!
That, though you give up bones, you may make old ones.

IN signing a certificate of death, a busy New York doctor signed his name in the blank line for "Cause of death." The registrar says he wishes all the physicians would be equally accurate.